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Quarterly Statistical Review

Alberta

SOCIAL SERVICES AND
COMMUNITY HEALTH
Research and Planning Division

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OCTOBER - DECEMBER 1974

Notes:

Data used in the construction of all figures contained within the Quarterly Statistical Review are available on request from Research and Planning.

Highlights of child welfare statistics are not included in this issue because of a five-month interruption in the operation of the child welfare statistical system. The monthly output from this system was halted in November, 1974, as a consequence of efforts to modify the basic table programs so that they would provide more accurate and relevant information. The operation of the system is scheduled to resume at the end of April, 1975. If this occurs, Highlights of Child Welfare statistics will appear in the next issue of the Review.

EMPLOYABILITY OF ALBERTA PUBLIC ASSISTANCE RECIPIENTS AND THEIR AVAILABILITY FOR EMPLOYMENT

Patricia Millar and Vivien Lai*

Increased labour shortages in Alberta in the past year have led to wide public and employer interest in the availability of persons on public assistance to fill vacant jobs. An additional emphasis on employability has come from the federal-provincial discussion on the development of a community employment strategy which is intended to provide employment services in a community in order that employment is the primary source of income for any persons who are employable and available for work. Additional discussions on the role of the employment strategy in the development of a reformed social security system by the federal government and the provinces have raised questions on the employability of the clients of such a system.

In considering whether individuals can take employment in the regular labour market (in areas where job opportunities exist) or alternatively whether they should be considered for special employment, sheltered employment, or job creation programs, both employability and availability to take a job must be considered. Employability refers to the factors which enable the person to compete in the labour market in order to find and hold a job; availability for work refers to whether they are free to take a job or whether they are already employed, in training or for some reason required to remain at home and therefore unavailable.

As a preliminary consideration of these concerns, the first section of this article presents a broad theoretical framework of the concept of employability using a systems approach typology followed by a discussion of relevant literature in the area assessed against the broad typology. In the second section of the article, findings are presented on the employability and availability of Alberta public assistance recipients for employment. The data analyzed in this section are from two sources:

(1) a study of public assistance recipients in March 1972 in which detailed data on employability and availability for employment were coded from information available in the public assistance file of the client

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(2) newly available data from the department's recently revised public assistance statistical information system, which provides detailed categories on the availability of clients for employment.

EMPLOYABILITY: A THEORETICAL FRAMEWORK AND LITERATURE REVIEW

THE FACTORS

Whether a person is able to find and hold a job is related to the interaction of a complex set of factors; some internal to the individual, others external. The individual with his various social, personality and skill attributes, interacts in job finding and employment situations in which there are varying skill requirements, level of performance expectations, and perceptions of who constitutes a desirable employee. This happens in a community where factors such as economic and labour market conditions determine the types and availability of jobs. A more complete list of factors affecting the employability of individuals is shown in Figure 1. This chart indicates three levels at which factors can affect employability - that of the individual, the employer and the community, each in turn composed of many factors and therefore referred to as subsystems. Employability is viewed as a complex social phenomena involving the interaction of factors within each subsystem and between the three systems. The importance of all three levels in determining who is employable at any given time can be illustrated by some examples:

Individual ⟷ Employer ⟷ Community

Example 1:

If job vacancies in a community increase, causing a labour shortage in certain sectors, employers may be forced to lower their expectations in terms of the skills and acceptable characteristics of employees hired by them. This may create opportunities for workers with a less advantaged position to enter the labour market and may change their employability status from unemployable to employable.

Example 2:

Due to labour shortages or public pressure at the community level employers and industries may be forced to pay equal wages to women and men. Over time this causes a shift in the structure of male and female wages in certain occupations making the labour market more attractive to women and stacking the trade off "to work or not to work" in the direction of working. Thus women, previously unemployable because they cannot make enough money working to offset the loss of their economic value in the home, may become employable.

Examples illustrating interaction within each subsystem are:

⟷ Individual

If a person from an unstable and low income family takes a training course to improve his number of marketable skills, other factors such as family conflict and calls from creditors may affect his ability to hold a job for any length of time. Thus his employability has been improved only partially.

⟷ Employer

A prospective employee may meet the skill and education requirements of an employer, but may not be hired due to a perceived conflict of lifestyle or personality, a factor contributing to lower employability in this situation.

⟷ Community

At the community level, changes in technology may reduce the number of jobs available in a certain industry, limiting the employment opportunities for persons with skills and experience in that industry. Thus their employability status has been lowered by a change in technology.

All of the variables in the chart are seen as interacting to constitute the condition "able to find and hold a job". The chart emphasizes the complexity of factors which must be taken into account in defining employability, the difficulties of measuring employability, and the limitations of the measurements presented in this article.

Unfortunately there is no available theoretical framework to link these variables, nor are there any studies to show which variables bear the strongest relationship to the ability to find and hold a job. The linkage between health, skills, work history, alcoholism, marital problems, family problems and employability are extensively described in the literature. However, the links between the ability to find and hold a job and such employer subsystem variables as employer expectations and hiring practices, or such community or macro-subsystem variables such as cost of living, minimum wage and financial incentive are not extensively described in the literature.

THE LITERATURE

Most studies of employability have focused on the individual subsystem, emphasizing social characteristics, skills, work history and personality of the individual, and have only briefly considered factors from the employer or community subsystem. Such studies are inadequate in the respect that they offer incomplete and over-simplified descriptions of what is involved in finding and holding a job.

> "We do not have an organized system of measuring those behaviors which are important in getting a job. Instead we use a psychopathological or medical model, with a few demographic variables thrown in for ease of measurement, then with a weak set of outcome measures we hope for good results."[1]

In general these studies which focus on individual characteristics such as the number of children, age, education, training, trade skill and the family background of welfare recipients who are not outside the labour force due to age or physical ill health, find male public assistance recipients to be of low education and skills with a high incidence of social problems such as debts, alcoholism and poor work histories.[2] A larger number of female public assistance recipients are generally found to have employment potential but to face a major obstacle to employment due to child care requirements.[3] An even more narrow focus on the individual has been taken by Maclean who studied the psychological characteristics of the hard core unemployed such as neuroticism and anxiety levels, and examines the theory that it is the interaction of individual and agency variables which leads to chronic welfare dependency. He proposes that habitual avoidance behavior is learned by the hard core unemployed male by coming in contact with the welfare system because it

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[1] W.C. Copeland, C.F. Kauppig and R.A. Walker, The MMPI as a Measure of Treatment Effects in Vocation Rehabilitation. Minneapolis: Minneapolis Rehabilitation Centre, Inc., 1966, pp. 1 - 3 as reported in Marvin Maclean, Rehabilitation of Chronic Welfare Recipients, M.A. Thesis, University of Alberta, 1971, p. 78.

[2] See (i) George Kupfer, George Diadio and Harland Magneson, Resource Mobilization for Employment. Edmonton, Alberta: The City of Edmonton Social Service Department, 1970;
(ii) Vivien Lai, Social Assistance Recipients in New Brunswick, New Brunswick: Department of Health and Welfare, 1971;
(iii) Clarence L. Barber, Welfare Policy in Manitoba, Winnipeg: Department of Economics, University of Manitoba, 1972;
(iv) Barry B. Swadron, Task Force on Employment Opportunities for Welfare Recipients, Toronto: Government of Ontario, 1972;
(v) Saskatchewan Department of Welfare, Employable Persons on Welfare. Regina: Research and Statistics, Department of Welfare, 1972;
(vi) S.G. Peitchinis, The Employability of Welfare Recipients, Edmonton: Human Resources Research Council, 1972.

[3] See (i) Perry Levinson, "How employable are AFDC Women?" Welfare in Review, (8:4), 1970, pp. 12 - 16;
(ii) Betty Burnside, "The Employment Potential of AFDC Mothers in Six States," Welfare in Review, July/August, 1971, pp. 16 - 19;
(iii) S.G. Peitchinis, op. cit.

relieves him from a pattern of anxiety caused by poor jobs, low recognition, low financial reward, and strained family relationships related to financial matters.[4]

The above mentioned studies of the individual and employability have considered the relationship between employability and most variables in the individual subsystem with the exception of values and aspirations. These have been studied extensively by Leonard Goodwin who found no differences between the poor and non-poor when it comes to life goals and wanting to work.[5] He suggests that the low work activity of welfare women is a result not of their rejecting the significance of work, but of their continually experiencing failure in the work world and thus finding welfare an acceptable alternative. Examinations of correlations between work activity and work orientations for men show that the lack of confidence orientation is most strongly related to work activity and the feeling of insecurity is directly relatable to lesser work force activity.

Studies which consider the relationship between the individual subsystem and the employer and community subsystems are less numerous. The one study which attempts to measure the position of the individual relative to the employment system he is entering found single employable welfare recipients registered at Canada Manpower to be less competitive in the job market than non-welfare recipient registrants due to age, lower education, and higher separation and divorce rates.[6] Kupfer, Diadio and Magneson measured the effect of the social service delivery system on the ability of hard core welfare recipients to remain employed and found that longer intensive counselling and financial contact is associated with longer duration of employment.[7]

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[4]Marvin Maclean, Personality Factors and Chronic Welfare Dependency, Ph. D. Thesis, Edmonton: University of Alberta, 1973.

[5]Leonard Goodwin, Do the Poor Want to Work?; Washington D.D.: The Brookings Institution, 1972, pp. 110 - 111.

[6]Barry Swadron, op. cit.

[7]George Kupfer, George Diadio and Harold Magneson, op. cit.

An illustration of the effect of some economic factors in the community subsystem have been provided in a study by Lai.[8] She has shown that most (78 per cent) Alberta public assistance recipients who are called unemployed employable remain on assistance for only three months and that they get off assistance at a much faster rate than other types of cases. It appears that the majority of this group use public assistance as a stopgap measure due to lack of income between jobs. Those who are on assistance for reason of age, illness or support of dependent children remain on assistance longer with over 40 per cent of age and illness cases remaining on longer than three years. Among mothers with dependent children 41 per cent were on for less than a year, and 30 per cent were on for more than three years. The major economic finding in the Lai study is that employment as a reason for going off assistance has increased for all groups from 24 per cent to 39 per cent in 1974, a trend which appears to be linked to improvements in the economy. More long-term as well as short-term public assistance cases were able to get off assistance during this improved economic period, clearly indicating that the economy itself, and the number of available jobs, to a certain extent determine who is able to find and hold a job at a given time.

As illustrated by the studies in the literature, the employability of persons on public assistance has mainly been viewed from the point of view of the individual without much consideration of the system in which he interacts. While available studies give an indication of some of the factors involved, many of those shown in Figure 1 have not been considered. Since the manner in which the problem of employability is perceived structures the types of employment and training services which are offered, more consideration needs to be given to the definition of this complex social phenomena in order to avoid programs which attempt over-simplistic solutions.

The study most similar to the findings to be presented in this article was done in Saskatchewan[9]; both it and the Alberta study are limited by the same types of narrow conceptualization as found in other studies, since they only measure variables in the individual system. However in the Saskatchewan study the employability of unemployed employable welfare

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[8] Vivien Lai, "Characteristics of Public Assistance Closed Cases", Quarterly Statistical Review, April - June 1974, pp. 1 - 10.

[9] Saskatchewan Department of Welfare, op. cit.

recipients was assessed on an individual basis taking into account all of their personal characteristics at the same time. This is in contrast to most of the studies which assessed group employability on each characteristic such as age and education separately, a type of analysis which does not provide specific enough estimates of the number of employable persons available for employment programs. To arrive at a measure of the number of employable persons, the Saskatchewan study first defined all persons with age and physical ill health problems as being outside of the labour force. Secondly, persons considered to be unemployable were:

(1) those 50 to 60 years of age having less than a grade 10 education,

(2) those having less than a grade 7 education,

(3) those considered marginal due to work indicators, and

(4) those who would have difficulty finding work due to identifiable social reasons.

The type and number of difficulties were recorded and found to be education, skill, training and experience deficiencies; followed by alcohol, other (drug use, obesity, loss of license, location), family and marital problems, and a criminal record. Using these criteria the researchers found 21 per cent of the clients called unemployed employables to be employable. In contrast 75 per cent of the clients felt that to assess themselves as employable was realistic. Social workers asked about the same clients felt that 60 per cent were employable. A major problem with this study is that specific criteria in determining unemployability by the researchers were not published and the study cannot be replicated.

THE ALBERTA CASE

The study of the employability of Alberta public assistance individuals and family heads was implemented using a random sample of public assistance cases (excluding cases receiving only health and medical services). This sample represented a 2.4 per cent (or approximately 1/40) random sample (stratified by reason for assistance) of the March 1972 social allowance cases that were active during the month. The Chi-square test was applied at the .05 level of significance and the sample was found to be similar and therefore representative of the social allowance population on the variables sex, age, education, and marital status. When the files were studied, it was found that some cases were erroneously coded or the files had not been closed even though the client had received no assistance for the month, and these cases were excluded.

The measurement of employability in this study was two fold: an objective measure of employability using the client's file, and a subjective assessment of employability by the social worker. Data on employability and work history, length of time on assistance, and basic demographic data were collected from clients' files. Data on trade skills were collected but clients' files proved to be a poor source of this type of data since work history and occupational data for women were often not available. Using a questionnaire, data were collected from social workers of the same clients on their perception of the client's ability to work, to compete in the regular labour market for jobs, any characteristics which might hinder the client in holding employment, and the client's willingness to take employment.

The categorization used by the researchers to assess the employability of the clients from their public assistance files was as follows:

(1) Not in the labour force due to age over 60, or obvious physical or mental ill health.

(2) Fully employable.

  (a) Has worked for at least two months during the 12 months prior to March 31, 1972.
  (b) Has no obvious social problems (alcohol, marital problems that affect work, debts, history of quarreling with boss).
  (c) Has no obvious psychological problems (self esteem, personality, neuroses).
  (d) Has no health problems that affect employment in his area of work.
  (e) Education more than Grade 7.
  (f) Age under 45.[10]

(3) Major problem work experience - meets conditions b to f, has had some work experience in the last four years but has had less than two months labour force attachment in the year prior to March 31, 1972.

(4) Major problem work experience - meets conditions b to f, has had no labour force attachment four years prior to March 31, 1972.

(5) Major problem health - meets conditions a, b, c, e, and f, has health problems that may affect employability.

(6) Major problem social - meets conditions a, c, d, e, and f, has social problems.

(7) Major problem psychological - meets conditions a, b, d, e, and f, has psychological problems.

(8) Others - those who are handicapped by two or more of a, b, c, d, e, and f (except e and f).

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[10] Conditions 'e' and 'f' were waived if 'a' to 'd' were met.

These employability items were developed out of a study of public assistance recipients in New Brunswick and the Saskatchewan study.[11] This measurement when compared to the theoretical framework has many weaknesses since it is a limited static measure which ignores the labour market conditions and jobs into which these clients might fit or the amount of competition they face. In addition to labour market factors, the measurement excludes the availability of transportation and day care and therefore it is likely to overestimate rather than underestimate the number of persons on public assistance available to enter the labour market. An additional factor contributing to an overestimation of employability is the use of client's files to collect the data, since Kupfer et al[12] have shown that clients show a much higher incidence of social problems when interviewed than those evident in their files.

In spite of these difficulties, however, the measurement is seen to have some strengths. Firstly, it provides a crude estimate of the size of target groups to which employment strategies might be directed. Secondly, the definition used is objective and measureable and therefore the study can be replicated with refinements of additional variables added to the scale if desirable. Some subjectivity remains in deciding what is a social, psychological or health problem which interferes with work in the labour force, however coders were uniformly trained and attempted to look for evidence that this had interfered with work in the past as one criteria and applied standardized criteria across all cases for the same problem. For example "chronic alcoholism" or "very bad nerves" were considered major obstacles to employment for every client where the notation appeared.

EMPLOYABILITY - TOTAL CASELOAD

According to the scale outlined in the study, and with a projection of the data to 1974, a very low 17.46 per cent of the public assistance caseload in Alberta were found to be employable (Table 1). These 5,359 fully employable persons were approximately equally divided among mothers with dependents (2621), and unemployed employables (2738). A large 82.54 per cent of public assistance clients were found to be outside the normal labour force or to have handicaps in finding and keeping employment (not

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[11] Vivien Lai, 1971 op. cit. and Saskatchewan Department of Welfare, op. cit.

[12] Kupfer, et al op. cit. pp. 68 - 70

fully employable). Approximately 47 per cent of the caseload were found to be outside the labour force for reasons of age, physical ill health and mental ill health (Table 1). Of the 52.98 per cent of the caseload who were potential or already labour force members (unemployed employables, employed with insufficient income cases, and mothers with dependent children), approximately one-third were found to have one or more major health, social or psychological disability preventing them from holding employment in the normal labour market. Thus 64.29 per cent of the total caseload were found to be not in the labour force or to have a weak competitive position in the labour force due to a major handicap and, therefore, not employable. An additional 18.25 per cent were not fully employable due to a lack of work experience, leaving only 17.47 per cent of the caseload fully employable according to the criteria in the scale. About five per cent of the caseload could not be assessed because their public assistance files contained insufficient information; this missing data has been excluded from the estimated percentages of employability.

EMPLOYABILITY - MOTHERS WITH DEPENDENTS AND UNEMPLOYED EMPLOYABLES

When comparing the employability of unemployed employables (single males and females, male family heads) to mothers with dependent children, the unemployed employable group were more likely to be fully employable (59.73 per cent compared to 22.46 per cent) (Table 2). This is due to the fact that the mothers were more likely to be lacking work experience than the unemployed employables (41.95 per cent as compared to 15.27 per cent) and were more likely to have one or more major problems in entering the labour force (35.59 per cent compared to 25.00 per cent).

If work experience is not considered as an essential criteria for employability then 35.71 per cent of the total social allowance caseload were employable (Table 1) with 75 per cent of unemployed employables and 64.41 per cent of mothers with dependents falling in this category (Table 2). This 35.71 per cent of the caseload were free from major social, psychological or health problems which would affect their labour force participation.

When work experience is considered a criteria in suitability to enter the labour force, unemployed employables had both the largest proportion employable and the largest absolute number employable (2,738 compared to 2,621 for mothers with dependents) (Table 2). However when work experience

is not considered a criteria, while unemployed employables had the largest proportion suitable to the labour market (75.00 per cent compared to 64.41 per cent), mothers with dependents represented the largest employable group on assistance in absolute numbers (7,517 compared to 3,438 for unemployed employables).

AVAILABILITY FOR EMPLOYMENT

In addition to considering whether a person is able to find and hold a job, one must consider whether he is available to enter the labour market in order to know if he might benefit from employment services of some type. In the previous section 17.47 per cent of the public assistance caseload were shown to be employable; however, when availability for employment was considered at February 1974 only 9.08 per cent (2,787) of the caseload were both fully employable and available for work (Table 3). The reason for this drop in percentage is that 42.84 per cent of those found fully employable on the scale were already employed or in training (Table 4). Approximately 11 per cent (1337/11671) of the mothers with dependents and 39 per cent (1780/4584) of the unemployed employables were both fully employable and available for work. These percentages are lower than when one looks at the concept of employability alone since approximately 49 per cent of the fully employable mothers and approximately 35 per cent of the unemployed employables were already employed at the time of the study (Table 4).

If work experience is not seen as essential to employability then 23.60 per cent (2,787 + 4,453) was seen as both available for employment and free from major handicaps in entering the labour force (Table 3). This is a lower percentage than if employability was considered alone since 28.45 per cent of those in the category free from major problems were found to be employed at the time of the study (Table 4). Therefore when work experience is not considered as a criteria in employability 46.60 per cent of mothers with dependents and 39.31 per cent of unemployed employables were both unemployed and free from problems in entering the labour force (Table 5). Approximately 24 per cent of the mothers with dependents and 39 per cent of the unemployed employables who were free from major problems in entering the labour force were found to be already employed at the time of the study (Table 4).

More important than the finding of 9.03 per cent of the total social allowance caseload being employable and available for work, was the finding

that when work experience is considered as a criteria of employability, over 90 per cent of the caseload were outside the normal labour force, unable to compete in the normal labour force, or already employed or in training (Table 3). If work experience is not considered in employability then 76.40 per cent of the caseload were either not in the normal labour force due to age or illness, had a major handicap in entering or keeping employment, or were already employed and in training.

If those who were unemployed and found to be fully employable or lacking only work experience can be considered truly potential labour force members then 17.73 per cent (5,438) of the total caseload were mothers with dependent children and 5.87 per cent (1,802) of the total caseload were employables who were potential labour force members (Table 3). This gives a total potential labour force of 23.60 per cent or 7,240 persons. Given the fact that this assessment does not take into account the job market in the area where the person lives, it is safe to conclude that there are no large numbers of employables on public assistance ready to enter the labour market.

The case of employable mothers with dependent children is a special one because of their need to care for children. Of the 64.41 per cent of mothers with dependent children who were fully employable or lacking work experience (Table 2), 40.71 per cent were perceived by social workers as being required to care for children (Table 6). The availability of mothers with dependent children to enter the labour market would therefore be strongly affected by the presence or absence of adequate child care arrangements.

Considering the 46.60 per cent (5,438) of mothers with dependent children who were both unemployed and free from major handicaps in terms of the labour force (Table 5), 8.62 per cent had children six years old or under, 49.99 per cent had children between seven and twelve, and 6.89 per cent had children in both age groups. Therefore about 66 per cent of the available employable women would require some form of child care or after school supervision for their children (Table 7). A smaller group of 34.48 per cent did not have any children under age 12.

THE PUBLIC ASSISTANCE INFORMATION SYSTEM EMPLOYABILITY DATA

Beginning in March 1974 the Department of Social Services and Community Health converted to a new public assistance statistical system which codes the availability of persons on public assistance for employment.

The data reported in this study are for November and December 1974. The findings from this data are similar to those found from the study of clients' files, indicating that only a very small number of public assistance recipients are suitable and available for employment in the regular labour market.

The data from the information system indicates that only 2,550 clients or 9.60 per cent of the total public assistance caseload are available for work and only 1,944 or 7.32 per cent for full time work (Table 7). Conversely 90.40 per cent of the total public assistance cases were unavailable for employment due to age (5,490 or 20.66 per cent), physical ill health (4,601 or 17.32 per cent), mental ill health (1,738 or 6.54 per cent), being unsuitable for employment (339 or 1.28 per cent), being already employed or in training (3.760 or 14.15 per cent), required to care for children (7,628 or 28.71 per cent), or other reasons (462 or 1.74 per cent). Another 0.59 per cent were available only for sheltered work and 0.88 per cent for part time work. Of those available for full time work, 70.37 per cent or 1,368 were employables and 25.15 per cent or 489 were persons with dependents. Only 50.20 per cent of the employables on public assistance were available for employment of any type because 47.88 per cent were already employed or in training. The remaining small group (other) were in such categories as expecting a child, or in jail.

Both the information system and the file study find similar proportions of persons called employables available for employment in the regular labour market (45.14 per cent for the former and 39.29 per cent in the latter)(Table 9). However there are some differences between the two data sources with the file study having found 23.81 per cent of employables unsuitable for employment while the information system classifies only 10.09 per cent in this category. This is due to two factors:

(1) the information system uses only health, social and psychological problems as employability criteria while the researchers also used age, education and work experience, and

(2) 43.05 per cent of those classified by the information system were employed (or in training) while only 36.90 per cent of the study cases were employed, and persons who are employed are by definition excluded from the definition of unemployable. Since the study was done in March 1972 and the information system data is for the last two months of 1974, differences in employment may be partially attributed to improvements in the economy between 1972 and 1974, a trend which has shown up in total caseload data between the two time periods.

The information system data provides similar findings for mothers with dependents to the study data. A low 7.01 per cent were available for employment in the regular labour market and a high 73.40 per cent of persons with dependents were seen as unavailable for work due to being required to care for children, according to the information system. In the study data 49.15 per cent of mothers with dependents were found to be employable and available for work (Table 9), but about 66 per cent of these would have needed some child care arrangements or after school supervision of children in order to enter the labour market, leaving a balance of only 16.53 per cent employable and available without day care. (This adjustment is shown in Table 10).

Contrary to the study data, the information system does not make the assumption that all aged clients and those with physical or mental disabilities are not in the labour force. Thus the information system data showed 3.37 per cent of the aged, 7.27 per cent of those with physical disabilities, 19.94 per cent of those with mental illness or mental retardation as being employed or available for work (Table 8). Lai has shown that the employability of these longer term cases tends to improve when the opportunities in the labour market increase. However, since their competitive position in the market is very weak, many of these persons are already in or require part time or sheltered employment.

If all aged and illness cases are considered to be outside the normal labour market, and those mothers requiring child care arrangements in order to enter the labour market are considered to be not immediately employable in the regular labour market, then both studies show the proportion of the public assistance caseload which is both employable and available for work to be around 8 or 12 per cent (only about 2,200 to 2,400 cases) (Table 10). If work experience is considered essential to employability the estimates from the data sources are even closer together with the study data giving an estimate of 9 per cent and the information system an estimate of 8 per cent.[13] It is clear from these study findings that the public assistance caseload does not represent a large labour pool for the regular labour market as is sometimes believed. In addition to

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[13] There are 72 cases unemployed and fully employable or lacking work experience giving an estimate of 11.85 per cent available to the labour market. When the 47 cases lacking work experience are subtracted this reduces the per cent employable to 7.73.

the fact that this percentage of employable and available persons is very low, the Lai study has shown this type of client remains on assistance for less than three months using assistance as a stopgap measure between jobs. Clearly the picture of persons choosing assistance over employment as a preferred lifestyle does not hold.

CONCLUSION

This article has presented a theoretical framework, literature review and data on the employability of persons receiving public assistance, using the Alberta caseload as a source of data. It has been shown that a large number of factors both external and internal to the individual affect his ability to find and hold a job. Using a set of objective criteria based on earlier studies, a number of individual characteristics were used to assess employability and availability for employment. Analysis of data from a file survey of public assistance cases and the public assistance information system show that only a small number of employables available for work are on assistance (8 - 12 per cent or about 2,200 to 2,400 cases) most of whom remain on assistance for three months or less using assistance only as a source of income between jobs. An additional 4,828 or 15.74 per cent are employable mothers who would require child care arrangements or after school supervision for children before entering the labour market.[14]

The estimates derived from the data, as low as they are, probably still remain an overestimate since many external factors shown in the conceptual framework such as location of jobs, employer attitudes, the earnings and the working conditions in potential jobs have not been taken into account in the measurement. Further work is needed to link the employability of welfare recipients to outside social and economic factors so that these can be taken into account in the planning of future employment programs.

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[14] This is the 77 mothers in Table 10 as required to care for children, all of whom came out of the available for regular labour market category in Table 9. This number is 15.74 per cent of the estimated February 1974 figure.

TABLE 1 ASSESSED EMPLOYABILITY OF THE ALBERTA SOCIAL ALLOWANCE CASELOAD, SAMPLE MARCH 1972 AND ESTIMATED FEBRUARY 1974*

	March 1972		February 1974	
	Sample		Estimated	
	#	%	#	%
OUTSIDE LABOUR FORCE Due to Age, Physical Ill Health and Mental Ill Health	288	45.93	14,424	47.02
TOTAL POTENTIAL LABOUR FORCE	339	54.07	16,255	52.98
No Major Problems	206	32.86	10,955	35.71
Fully Employable[a]	96	15.32	5,359	17.46
Lacking Work Experience	110	17.54	5,596	18.25
Major Problems	102	16.27	5,300	17.27
One of Health, Social or Psychological Problems	21	3.35	1,082	3.51
Multiple Problems	81	12.92	4,218	13.76
Insufficient Information	31	4.94	-	-
MOTHERS WITH DEPENDENT CHILDREN	254	40.51	11,671	38.04
No Major Problems	152	24.24	7,517	24.50
Fully Employable	53	8.45	2,621	8.54
Lacking Work Experience	99	15.79	4,896	15.96
Major Problems	84	13.40	4,154	13.54
One of Health, Social or Psychological Problems	18	2.87	891	2.90
Multiple Problems	66	10.53	3,263	10.64
Insufficient Information	18	2.87	-	-
UNEMPLOYED EMPLOYABLE	85	13.56	4,584	14.94
No Major Problems	54	8.61	3,438	11.21
Fully Employable	43	6.86	2,738	8.93
Lacking Work Experience	11	1.75	700	2.28
Major Problems	18	2.87	1,146	3.73
One of Health, Social or Psychological Problems	3	0.48	191	0.61
Multiple Problems	15	2.39	955	3.12
Insufficient Information	13	2.08	-	-
TOTAL[b]	627	100.00	30,679	100.00

* Estimation technique: The sample data collected in March 1972 is projected to February 1974, with adjustment to reflect changes in the distributions of reasons for assistance which have taken place between 1972 and 1974. Missing data have been included from the estimated column.

[a] Fully employable is defined as age under 45, education greater than grade seven, no obvious social, psychological or health problems and has worked two of the last 12 months.

[b] Fathers with dependent children have been excluded from the analysis. These numbered 112 in March 1972.

TABLE 2 COMPARISON OF THE EMPLOYABILITY OF MOTHERS WITH DEPENDENTS AND UNEMPLOYED EMPLOYABLES, SAMPLE MARCH 1972 AND ESTIMATED FEBRUARY 1974*

	SAMPLE MARCH 1972						ESTIMATED FEBRUARY 1974					
	Mothers With Dependents		Unemployed Employable		Total		Mothers With Dependents		Unemployed Employable		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
No Major Problems	152	59.85	54	63.53	206	60.77	7517	64.41	3438	75.00	10955	67.39
Fully Employable[a]	53	20.87	43	50.59	96	28.32	2621	22.46	2738	59.73	5359	32.97
Lacking Work Experience	99	38.98	11	12.94	110	32.45	4896	41.95	700	15.27	5596	34.42
Major Problems	84	33.07	18	21.18	102	30.09	4154	35.59	1146	25.00	5300	32.61
One of Health, Social or Psychological Problems	18	7.09	3	3.53	21	6.19	891	7.63	191	4.17	1082	6.66
Multiple Problems	66	25.98	15	17.65	81	23.90	3263	27.96	955	20.83	4218	25.95
Insufficient Information	18	7.08	13	15.29	31	9.14	-	-	-	-	-	-
TOTAL[b]	254	100.00	85	100.00	339	100.00	11671	100.00	4584	100.00	16255	100.00

*Estimation technique: The sample data collected in March 1972 is projected to February 1974, with adjustment to reflect changes in the distributions of reasons for assistance which have taken place between 1972 and 1974. Missing data have been included from the estimated column.

[a]Fully employable is defined as age under 45, education greater than grade seven, no obvious social, psychological or health problems, and has worked two of the last 12 months.

[b]Fathers with dependent children have been excluded from the analysis. These numbered 112 in March 1972.

TABLE 3 ASSESSED EMPLOYABILITY AND EMPLOYMENT STATUS OF THE ALBERTA SOCIAL ALLOWANCE CASELOAD, SAMPLE MARCH 1972 AND ESTIMATED FEBRUARY 1974*

	March 1972		February 1974	
	Sample		Estimated[a]	
	#	%	#	%
OUTSIDE LABOUR FORCE				
Due to Age, Physical Ill Health, Mental Ill Health	288	45.94	14424	47.02
TOTAL POTENTIAL LABOUR FORCE	339	54.06	16255	52.98
Unemployed	242	38.65	11689	38.10
No Major Problems	149	23.78	7240	23.60
Fully Employable [a]	55	8.78	2787	9.08
Lacking Work Experience	94	15.00	4453	14.52
Major Problems (Health, Social, Psychological)	93	14.87	4449	14.50
Employed, In Training	70	11.16	3524	11.49
Insufficient Information	27	4.25	1042	3.39
MOTHERS WITH DEPENDENT CHILDREN	254	40.48	11671	38.04
Unemployed	197	31.45	9232	30.09
No Major Problems	116	18.51	5438	17.73
Fully Employable	27	4.31	1260	4.11
Lacking Work Experience	89	14.20	4178	13.62
Major Problems (Health, Social, Psychological)	81	12.94	3794	12.36
Employed, In Training	39	6.22	1832	5.97
Insufficient Information	18	2.81	607	1.98
UNEMPLOYED EMPLOYABLES	85	13.58	4584	14.94
Unemployed	45	7.20	2457	8.01
No Major Problems	33	5.27	1802	5.87
Fully Employable	28	4.47	1527	4.97
Lacking Work Experience	5	0.80	275	0.90
Major Problems (Health, Social, Psychological)	12	1.93	655	2.14
Employed, In Training	31	4.94	1692	5.52
Insufficient Information	9	1.44	435	1.41
TOTAL[b]	627	100.00	30679	100.00

*Estimation technique: The sample data collected in March 1972 is projected to February 1974, with adjustment to reflect changes in the distributions of reasons for assistance which have taken place between 1972 and 1974. Missing data have been included from the estimated column.

[a] Fully employable is defined as age under 45, education greater than grade seven, no obvious social, psychological or health problems and has worked two of the last 12 months.

[b] Fathers with dependent children have been excluded from the analysis. These numbered 112 in March 1972.

TABLE 4 COMPARISON OF EMPLOYABILITY OF MOTHERS WITH DEPENDENTS AND UNEMPLOYED EMPLOYABLES, SAMPLE MARCH 1972 AND ESTIMATED FEBRUARY 1974*

	SAMPLE MARCH 1972						ESTIMATED FEBRUARY 1974					
	Not Employed		Employed or In Training		Total		Not Employed		Employed or In Training		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Mothers and Employables	263	77.58	76	22.42	339	100.00	12605	77.55	3650	22.45	16255	100.00
No Major Problems	149	72.33	57	27.67	206	100.00	7838	71.55	3117	28.45	10955	100.00
Fully Employable[a]	55	57.29	41	42.71	96	100.00	3117	58.16	2242	41.84	5359	100.00
Lacking Work Experience	94	85.45	16	14.55	110	100.00	4721	84.36	875	15.64	5596	100.00
Major Problems	93	91.18	9	8.82	102	100.00	4767	89.94	533	10.06	5300	100.00
One of Health, Social or Psychological Problem	17	80.95	4	19.05	21	100.00	867	80.13	215	19.87	1082	100.00
Multiple Problems	76	93.83	5	6.17	81	100.00	3900	92.46	318	7.54	4218	100.00
Insufficient Information	21	67.74	10	32.26	31	100.00	--	--	--	--	--	--
Mothers With Dependents	210	82.68	44	17.32	254	100.00	9746	83.51	1925	16.49	11671	100.00
No Major Problems	116	76.32	36	23.68	152	100.00	5743	76.40	1774	23.60	7517	100.00
Fully Employable	27	50.94	26	49.06	53	100.00	1337	51.01	1284	48.99	2621	100.00
Lacking Work Experience	89	89.90	10	10.10	99	100.00	4406	89.99	490	10.01	4896	100.00
Major Problems	81	96.43	3	3.57	84	100.00	4003	96.36	151	3.64	4154	100.00
One of Health, Social or Psychological Problems	15	83.33	3	16.67	18	100.00	740	83.05	151	16.95	891	100.00
Multiple Problems	66	100.00	-	-	66	100.00	3263	100.00	-	-	3263	100.00
Insufficient Information	13	72.22	5	27.78	18	100.00	-	-	-	-	-	-
Unemployed Employables	53	62.35	32	37.65	85	100.00	2859	62.37	1725	37.63	4584	100.00
No Major Problems	33	61.11	21	38.89	54	100.00	2095	60.94	1343	39.06	3438	100.00
Fully Employable	28	65.12	15	34.88	43	100.00	1780	65.01	958	34.99	2738	100.00
Lacking Work Experience	5	45.45	6	54.55	11	100.00	315	45.00	385	55.00	700	100.00
Major Problems	12	66.67	6	33.33	18	100.00	764	66.67	382	33.33	1146	100.00
One of Health, Social or Psychological Problems	2	66.67	1	33.33	3	100.00	127	66.49	64	33.51	191	100.00
Multiple Problems	10	66.67	5	33.33	15	100.00	637	66.70	318	33.50	955	100.00
Insufficient Information	8	61.54	5	38.46	13	100.00	-	-	-	-	-	-

*Estimation technique: The sample data collected in March 1972 is projected to February 1974, with adjustment to reflect changes in the distributions of reasons for assistance which have taken place between 1972 and 1974. Missing data have been included from the estimated column.

[a]Fully employable is defined as age under 45, education greater than grade seven, no obvious social, psychological or health problems, and has worked two of the last 12 months.

TABLE 5 COMPARISON OF THE EMPLOYABILITY AND EMPLOYMENT STATUS OF MOTHERS WITH DEPENDENTS AND UNEMPLOYED EMPLOYABLES, SAMPLE MARCH 1972 AND ESTIMATED FEBRUARY 1974*

	Sample March 1972						Estimated February 1974					
	Mothers With Dependents		Unemployed Employables		Total		Mothers With Dependents		Unemployed Employables		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Unemployed	197	77.56	45	52.94	242	71.39	9232	79.10	2457	53.60	11689	71.91
No Major Problems	116	45.67	33	38.82	149	43.96	5438	46.60	1802	39.31	7240	44.54
Fully Employable[a]	27	10.63	28	32.94	55	16.23	1260	10.80	1527	33.31	2787	17.15
Lacking Work Experience	89	35.04	5	5.88	94	27.73	4178	35.80	275	6.00	4453	27.39
Major Problems	81	31.89	12	14.12	93	27.43	3794	32.50	655	14.29	4449	27.37
One of Health, Social or Psychological Problems	15	5.91	2	2.36	17	5.01	701	6.00	110	2.40	811	4.99
Multiple Problems	66	25.98	10	11.76	76	22.42	3093	26.50	545	11.89	3638	22.38
Employed, In Training	39	15.35	31	36.47	70	20.65	1832	15.70	1692	36.91	3524	21.68
Insufficient Information	18	7.09	9	10.59	27	7.96	607	5.20	435	9.49	1042	6.41
TOTAL	254	100.00	85	100.00	339	100.00	11671	100.00	4584	100.00	16255	100.00

*Estimation technique: The sample data collected in March 1972 is projected to February 1974, with adjustment to reflect changes in the distributions of reasons for assistance which have taken place between 1972 and 1974. Missing data have been included from the estimated column.

[a]Fully employable is defined as age under 45, education greater than grade seven, no obvious social, psychological or health problems and has worked two of the last 12 months.

TABLE 6 COMPARISON OF ASSESSED EMPLOYABILITY OF ALBERTA MOTHERS WITH DEPENDENT CHILDREN WITH SOCIAL WORKER'S PERCEPTION OF THEIR AVAILABILITY FOR EMPLOYMENT, 1972

Assessment of Employability	Social Worker's Perception of Employment Status: Not Employed[a] and Available for Work #	%	Employed #	%	Temporarily or Permanently Unavailable due to Illness, Training or Age #	%	Temporarily Unavailable due to Required to Care for Children #	%	Total #	%
POTENTIAL LABOUR FORCE										
No Major Problems	22	19.47	26	23.01	19	16.81	46	40.71	113	100.00
Fully Employable[b]	6	17.65	15	44.12	7	20.58	6	17.65	34	100.00
Lacking Work Experience	16	20.25	11	13.92	12	15.19	40	50.64	79	100.00
Major Problems										
One of Health, Social, or Psychological Problems or Multiple Problems	6	9.09	4	6.06	24	36.37	32	48.48	66	100.00
TOTAL[c]	28	15.64	30	16.76	43	24.02	78	43.58	179	100.00

[a] Employment Status is that recorded by the social worker on the social worker questionnaire at September 1972.

[b] Fully employable is defined as age under 45, education greater than grade seven, no obvious social, psychological, or health problems, and has worked two of the last 12 months.

[c] Excludes 75 cases of missing data.

TABLE 7 NUMBER AND AGE OF CHILDREN OF UNEMPLOYED MOTHERS WITH DEPENDENT CHILDREN WHO ARE ASSESSED AS FULLY EMPLOYABLE OR LACKING WORK EXPERIENCE, ALBERTA, MARCH 1972

Number of Children Under 12 Years	Cases	
	#	%
Total with children 12 years or younger	76	65.52
Two children 6 years or younger	6	5.17
Three children 6 years or younger	4	3.45
One child 7 - 12 years	30	25.85
Two children 7 - 12 years	10	8.62
Three children 7 - 12 years	18	15.52
Three children both age groups	6	5.17
Four children both age groups	2	1.72
No children 12 years or younger	40	34.48
TOTAL	116	100.00

TABLE 8 AVERAGE MONTHLY SOCIAL ALLOWANCE CASES BY EMPLOYMENT STATUS AND REASON FOR ASSISTANCE, ALBERTA, NOVEMBER - DECEMBER 1974

	REASON FOR ASSISTANCE													
	Aged		Persons with Dependent Children		Physical Illness or Disability		Mental Illness and Mental Retardation		Employable		Unsuitable for Employment		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
In the Labour Force														
Employed or In Training:														
Employed	18	0.32	594	5.72	47	0.95	45	2.07	813	26.91			1517	5.71
Part-time - not seeking full-time and self-employed	135	2.38	520	5.00	144	2.90	209	9.62	193	6.38			1201	4.52
Attending school up to and including Grade 12	-	-	110	1.06	20	0.40	17	0.78	350	11.58			497	1.87
Attending technical or vocational training and attending post-secondary education	1	0.02	403	3.87	36	0.72	14	0.64	91	3.01			545	2.05
Subtotal	154	2.72	1627	15.65	247	4.97	285	13.11	1447	47.88			3760	14.15
Available for Work:														
Available for full-time work	22	0.39	489	4.70	48	0.97	17	0.78	1368	45.27			1944	7.32
Available for part-time work	8	0.14	168	1.62	19	0.38	3	0.14	35	1.16			233	0.88
Available for sheltered work	-	-	5	0.05	33	0.67	120	5.53	-	-			158	0.59
Working part-time; seeking or encouraged to seek full-time	7	0.12	72	0.69	14	0.28	8	0.37	114	3.77			215	0.81
Subtotal	37	0.65	734	7.06	114	2.30	148	6.82	1517	50.20			2550	9.60
Total in the Labour Force	191	3.37	2361	22.71	361	7.27	433	19.93	2964	98.08			6310	23.75
Not in the Labour Force														
Unavailable to work due to illness or age:														
Illness up to 90 days	16	0.28	82	0.79	556	11.21	66	3.04	-	-			720	2.71
Illness 90 days or over	382	6.72	234	2.25	3468	69.89	1112	51.17	-	-			5196	19.56
Age	4935	86.87	-	-	-	-	-	-	-	-			4935	18.57
Subtotal	5333	93.87	316	3.04	4024	81.10	1178	54.21	-	-			10851	40.84
Unavailable to work due to other reasons:														
Required to care for children	39	0.68	7628	73.40	-	-	-	-	-	-			7667	28.86
Others	1	0.02	26	0.25	152	3.06	2	0.09	58	1.92			239	0.90
Subtotal	40	0.70	7654	73.65	152	3.06	2	0.09	58	1.92			7906	29.76
Unsuitable for Employment	117	2.06	62	0.60	425	8.57	560	25.77	-	-	339	100.00	1503	5.65
Total Not in the Labour Force	5490	96.63	8032	77.29	4601	92.73	1740	80.07	58	1.92	339	100.00	20260	76.25
TOTAL[a]	5681	100.00	10393	100.00	4962	100.00	2173	100.00	3022	100.00	339	100.00	26570	100.00

[a] Excludes 2,418 cases of missing data.

TABLE 9 COMPARISON OF DATA FROM THE MARCH 1972 FILE STUDY WITH THE INFORMATION DATA, ALBERTA, NOVEMBER - DECEMBER 1974 (NOT ADJUSTED FOR DEFINITIONAL DIFFERENCES)

	Aged, Physical Ill Health, Mental Ill Health & Retardation				Persons with Dependents[a]				Employables[b]				TOTAL			
	File Study		Information System		File Study		Information System		File Study		Information System		File Study		Information System	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Not in the Labour Force																
Unsuitable for Employment[c], Illness or Age	288	100.00	11637	90.80	81	34.32	378	3.64	20	23.81	339	10.09	389	63.98	12354	46.50
Required to Care for Children	n/a		39	0.30	n/a		7628	73.40	n/a		-	-	n/a		7667	28.86
Other	n/a		155	1.21	n/a		26	0.25	n/a		58	1.73	n/a		239	0.90
Subtotal	288	100.00	11831	92.31	81	34.32	8032	77.29	20	23.81	397	11.81	389	63.98	20260	76.25
In Labour Force																
Employed or In Training	n/a		686	5.35	39	16.53	1627	15.65	31	36.90	1447	43.05	70	11.51	3760	14.15
Available for Regular Labour Market	n/a		146	1.14	116	49.15	729	7.01	33	39.29	1517	45.14	149	24.51	2392	9.00
Available for Sheltered Employment	n/a		153	1.20	n/a		5	0.05	-	-	-	-	-	-	158	0.59
Subtotal	-	-	985	7.69	155	65.68	2361	22.71	64	76.19	2964	88.19	219	36.02	6310	23.75
TOTAL	288	100.00	12816	100.00	236	100.00	10393	100.00	84	100.00	3361	100.00	608	100.00	26570	100.00

[a] Not entirely comparable since Fathers with Dependent Children are excluded from the study and included in the information system. This group numbered 163 in the last quarter of 1974.

[b] For the information system column Employables and Unsuitable for Employment have been added to make this column comparable to the study data.

[c] Unsuitable for employment refers to social, psychological and work problems.

TABLE 10 COMPARISON OF DATA FROM THE MARCH 1972 FILE STUDY WITH INFORMATION SYSTEM DATA, ALBERTA, NOVEMBER - DECEMBER 1974 (ADJUSTED FOR DEFINITIONAL DIFFERENCES)

	Aged, Physical Ill Health, Mental Ill Health & Retardation						Persons with Dependents[a]						Employables[b]						TOTAL					
	File Study		Estimated Feb. 1974		Information System		File Study		Estimated Feb. 1974		Information System		File Study		Estimated Feb. 1974		Information System		File Study		Estimated Feb. 1974		Information System	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Not in the Labour Force																								
Unsuitable for Employment[c], Illness or Age	288	100.00	14,424	100.00	12,622	98.50	81	34.32	4,401	37.71	378	3.64	20	23.81	1,090	23.8	339	10.09	389	63.98	19,915	64.91	13,339	50.20
Required to Care for Children	n/a		n/a		39	0.30	77	32.62[d]	4,828	41.37	7,628	73.40	n/a		n/a				77	12.66	4,828	15.74	7,667	28.86
Other	n/a		n/a		155	1.20	n/a				26	0.25	n/a		n/a		58	1.73	n/a				239	0.90
Subtotal	288	100.00	14,424	100.00	12,816	100.00[d]	158	66.94	9,229	79.08	8,032	77.29	20	23.81	1,090	23.8	397	11.81	466	76.64	24,743	80.65	21,245	79.96
In Labour Force																								
Employed or In Training	n/a		n/a		n/a		39	16.53	1,832	15.70	1,627	15.65	31	36.90	1,692	36.9	1,447	43.05	70	11.51	3,524	11.49	3,074	11.58
Available for Regular Labour Market	n/a		n/a		n/a		39	16.53	610	5.23	729	7.01	33	39.29	1,802	39.3	1,517	45.14	72	11.85	2,412	7.86	2,246	8.44
Available for Sheltered Employment	n/a		n/a		n/a		n/a				5	0.05											5	0.02
Subtotal	-	-	-	-	-	-	78	33.06	2,442	20.92	2,361	22.71	64	76.19	3,494	76.2	2,964	88.19	142	23.36	5,936	19.35	5,325	20.04
TOTAL	288	100.00	14,424	100.00	12,816	100.00	236	100.00	11,671	100.00	10,393	100.00	84	100.00	4,584	100.00	3,361	100.00	608	100.00	30,679	100.00	26,570	100.00

[a]Not entirely comparable since Fathers with Dependent Children are excluded from the study and included in the information system. This group numbered 163 in the last quarter of 1974.

[b]For the information system column Employables and Unsuitable for Employment have been added to make this column comparable to the study data.

[c]Unsuitable for employment refers to social, psychological and work problems.

[d]Adjusted for comparability of the two data sources.

FIGURE 1 INTERACTING SYSTEMS AND SYSTEM VARIABLES AFFECTING THE EMPLOYABILITY OF INDIVIDUALS*

The Individual Subsystem	The Employer Subsystem	The Community Subsystem
Physical Factors Conditions of physical health Conditions of mental health Number of children	**Physical Factors** Type of industry Type and size of company Unionized or non-unionized jobs	**Physical Factors** Availability of food, clothing, shelter Availability of health care Availability of transportation Availability of child care Weather and climate conditions
Psychological Factors Personality characteristics Level of inter-personal skills Level of self-esteem Level of self-confidence	**Psychological Factors** Personality of employer Personality of fellow employees Level of tolerance for deviance of employer Level of tolerance for deviance of fellow workers	**Psychological Factors** Availability of preventative services related to psychological well being Availability of rehabilitative services related to psychological well being
Social Factors Level of stability in family relationship Peer group, reference group relations Presence or absence of alcoholism or drug addiction	**Social Factors** Employer perception of a desirable employee: age language race culture appearance work record behavior record (presence or absence of a prison record) Relationship with fellow employees	**Social Factors** Amount of stress on family and inter personal relationships caused by present societal emphasis on the individual, urbanization and industrialization Availability of services to deal with breakdowns in family and inter-personal relationships
Economic Factors Adequacy and stability of income Amount of pressure related to debts Access to credit Whether better off working than not	**Economic Factors** State of the employer's business Wage rates Working conditions Geographic location of jobs	**Economic Factors** Condition of the economy Number of the jobs available Type of jobs available Location of jobs available Cost of living Minimum wage Structure of wages in the male and female occupations
Skills Level of education Number of marketable skills Adaptability Lanquage Job search skills Knowledge of job location Knowledge of budgeting and nutrition Knowledge of available services and agencies	**Skills** Type and level of education required by employer Type of skills required by employer	**Skills** Types of technology Rates of change of technology
Values and Aspirations Values toward work Values toward life style Career aspirations	**Values and Aspirations** Values toward employee performance on the job Values toward employee's life style	**Values and Aspirations** Prevailing attitudes toward value of work Prevailing attitudes toward those who do not work Types of persons the community is willing to support by income maintenance schemes

*Developed in discussion with Erick Schmidt, Westrede Institute, Edmonton, Alberta

VENEREAL DISEASE PROGRAMS IN BRITAIN, WEST GERMANY, DENMARK AND SWEDEN, WITH IMPLICATIONS FOR CANADA

Dr. E.S.O. Smith*

INTRODUCTION

The author was awarded a WHO Travel Fellowship to study venereal disease control and family planning programs in Britain, West Germany, Denmark and Sweden. He spent two weeks in each country between December 1974 and February 1975. This report covers only the venereal disease aspects of the tour.

INCIDENCE RATES AND TRENDS - GONORRHOEA

The incidence of reported cases of gonorrhoea, by sex, in each of the four countries during 1973 is compared with the incidence in Canada in Table I. Since statistics for England are published separately from and were more readily available than those for Wales, Scotland and Northern Ireland, rates for England have been used in place of those for Britain as a whole. While the incidence of reported cases, for reasons which will become apparent, is probably fairly realistic in England, Denmark and Sweden, it almost certainly represents an under-estimate in West Germany, as in Canada. The true incidence in West Germany is likely to be intermediate between that of England on the one hand and those of Denmark and Sweden on the other, while the true incidence in Canada is likely to be even higher than those of the Scandinavian countries.

Trends in the incidence of reported gonorrhoea during the five-year period 1969-73 are shown in Table II. Since under-reporting does not necessarily affect trends, the trends indicated for West Germany and Canada may well reflect the actual situation. In England the incidence has been increasing; in West Germany and Denmark the incidence has fallen slightly after a peak in 1972; in Sweden there has been a marked drop in incidence since 1970; while in Canada the incidence has been rapidly increasing throughout the five-year period.

INCIDENCE RATES AND TRENDS - SYPHILIS

The incidence of reported cases of infectious syphilis, by sex, in each of the four countries during 1973 is compared with the Canadian

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*Dr. Smith is the director of Epidemiology in Research and Planning.

incidence in Table III. Although the criteria for reporting syphilis vary from country to country, every effort has been made to ensure consistency in the compilation of this table. In view of the more serious implications of syphilis, under-reporting is likely to be less of a problem with this disease than with gonorrhoea. West Germany has about three times the incidence rate of England, while the Scandinavian countries and Canada have roughly twice the English rate. However, perhaps one of the most striking features of this table is the ratio of male to female incidence, which in Denmark exceeds 5.5 to 1 and in England exceeds 6.0 to 1; this marked departure from the traditional ratio of approximately 2.0 to 1 reflects the increasing concentration of syphilis among homosexual males. Venereologists in London, England, estimated that homosexual males accounted for 75 per cent to 80 per cent of the infectious syphilis in that metropolis.

Trends in the incidence of reported infectious syphilis during the five-year period 1969-73 are shown in Table IV. While the incidence in West Germany and Denmark appears to be fairly static, the incidence in England and Sweden has been risirg steadily since 1970 and in Canada has increased rapidly since 1971.

REPORTING

In Britain the term "venereal diseases" (VD) has been replaced by the term "sexually transmitted diseases" (STD). In England, all STD clinics submit to the Department of Health and Social Security quarterly statistical reports (see Appendix A) covering the whole range of sexually transmitted diseases. The list includes not only the traditionally recognized venereal diseases (gonorrhoea, syphilis, chancroid, lymphogranuloma venereum and granuloma inguinale), but also non-specific genital infection (e.g. non-specific urethritis), trichomoniasis, candidiasis, scabies, pediculosis pubis, genital herpes, genital warts and molluscum contagiosum. There is no reporting of cases by name, even by physicians in private practice.

In West Germany legislation was introduced in 1969, and became effective the 1st July 1970, making it compulsory for any physician treating a contagious case of a venereal disease to report the occurrence to the health office for the district in which he practises, but without mentioning the name or address of the patient. Details to be reported include

diagnosis (only the traditionally recognized venereal diseases are notifiable), sex, age and marital status. Federal and Land (provincial) statistics are based upon the aggregation of these reports.

In Denmark every physician is required to submit to the health office for the county in which he practises a weekly statistical report (see Appendix B) of all infectious diseases, including the common cold. The traditionally recognized venereal diseases are individually listed, and the form provides for an analysis of the cases of each disease by sex and age, with some additional information on each patient with syphilis. Physicians in venereal disease clinics and even medical officers of health, who have a time-honoured responsibility for treating venereal diseases, use the same reporting forms as all other physicians, and there is no reporting of cases by name unless a patient defaults from treatment.

In Sweden the reporting system is similar to that in West Germany. A physician who treats a patient with a venereal disease must submit to the health office for the county in which he practises the same kind of report as he submits for any other notifiable communicable disease (see Appendix C), with the exception that the patient's name and address are omitted. The list of reportable venereal diseases follows the standard pattern.

In most provinces of Canada a physician who treats a patient with a venereal disease is required to submit to the provincial health department (either directly or through the local health unit, depending upon the province) an individual report in which the patient is identified by name. This lack of anonymity in the Canadian reporting system is disliked by physicians as well as by patients, and undoubtedly contributes to the under-reporting which is known to exist, particularly in relation to gonorrhoea.

SERVICES FOR TREATMENT OF VENEREAL DISEASES

Britain is amply provided with special clinics for the treatment of sexually transmitted diseases. In England alone there are more than 200 such clinics, all or nearly all being hospital-based and all administered by the hospital system. The clinics are staffed or supervised by specialists who are consultants in venereology, and all treatment is free. Their locations are well advertised in public lavatories, and most people who suspect that they have a venereal disease go straight to a clinic. Those

who consult a general practitioner first are usually referred to a clinic, partly because the general practitioners recognize the need for specialized investigation and for the tracing of contacts and partly because, when they are paid on a capitation basis rather than a fee-for-service basis,[1] they see little point in duplicating a service which is already being provided. In the large cities there are a few venereologists who do private consultant practice on a part-time basis, outside the National Health Service, but the volume of patients seen by them is small by comparison with the clinic population.

In West Germany treatment for venereal diseases is undertaken almost entirely by general practitioners and by specialists in dermatology who also practise venereology. A patient does not need to be referred by a general practitioner in order to consult a specialist in his office, but he does require a doctor's referral in order to visit any kind of hospital out-patient clinic except one that is associated with a university. Some local health departments provide VD consultatory services, but in the particular city health department visited by the author, patients requiring treatment were referred to private physicians. If a patient consults the local health department, or if his physician, finding him to be suffering from a notifiable infection, reports the case to the local health office, it is not necessary for him to produce a sickness insurance card in order that treatment may be paid for; a young person can therefore escape the embarrassment of having to ask his parents for the family's sickness insurance card.

In Denmark a person who suspects that he has a venereal disease may go either to a public clinic, usually hospital-based, or to a general practitioner or a specialist in dermatology and venereology, as he perfers. If he goes to a public clinic, treatment is free. If he chooses to consult a physician in his private office, the cost of treatment, including the cost of drugs, is covered in whole or in part (depending upon his income level) by the national health insurance scheme.

Services in Sweden are similar to those in Denmark. A person who suspects that he has a venereal infection has the choice of going to a

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[1] Under the National Health Service every person must register with the general practitioner of his choice; the general practitioner then receives from the state an annual fee for each patient on his list.

hospital out-patient clinic, to a district medical officer, or to a private practitioner. If a district medical officer considers it necessary to refer the patient to a specialist (a dermatovenereologist), he assumes this responsibility. There is normally a basic charge of SKr 12 (around $3.00) for each visit to a hospital out-patient clinic or to a district medical officer, but this fee is waived for a patient who requests an examination for VD or in whom the diagnosis of one of the recognized venereal diseases is confirmed. By the same token there is a maximum charge of SKr 15 (around $3.75) for drugs, but this charge is also waived if the treatment is for a venereal disease.

By way of comparison, treatment for venereal diseases in Canada is available both from private physicians and from provincial or municipal clinics. For a patient who is covered by medical care insurance there is usually no charge for a visit to a private physician, and for a patient in whom the diagnosis of a venereal disease is confirmed and in respect of whom a report is submitted to the provincial health department, the drugs are provided free. However, provincial and municipal clinics are usually located only in the major cities, some of them are not hospital-based, and some do not provide treatment for patients who are found to have infections other than those which are officially listed as venereal diseases.

TRACING OF CONTACTS

Assigned to each STD clinic in England there is at least one social health worker whose business is to interview patients, particularly those with syphilis or gonorrhoea, in an attempt to ascertain the source of their infection and to identify persons who may have been infected by them. The patient is given an opportunity to trace his own contacts, and to facilitate his task he is provided with one or more contact slips (see Appendix D); his partner is requested to attend a clinic in person and to present the slip, which is returned to the originating clinic as soon as the presence or absence of disease in the partner has been confirmed. The system works well, and substantially reduces the amount of time and effort which the social health worker has to devote to following up contacts at home, at work or wherever they are to be found.

In West Germany the physician who reports a case of VD is asked to obtain from the patient as much identifying information as possible about

contacts and to record this on the form, but it would appear that the information provided is rarely sufficient to enable field workers from the local health office to trace the person or persons concerned.

In Denmark, until about two years ago, a patient with a venereal disease was obliged by law to reveal information about his sexual contacts. He can no longer be compelled, but usually he can still be persuaded. A physician who diagnoses a venereal disease is often prepared to go to a considerable amount of trouble to elicit the necessary information from his patient, and he himself may ask the contacts to present themselves for examination. In most public clinics the patients are interviewed by social workers, and the contact tracing is done by them. A contact who fails to respond to a request to appear for an examination may be ordered to appear, and can be forcibly compelled.

In Sweden the physician who reports a case of VD is expected to obtain from the patient enough identifying information about his contacts to enable the county health authorities to trace them by mail, telephone or personal visit and to invite them to submit to an examination. In public clinics, as in Denmark, the patients are interviewed by social workers, but again the follow-up of the contacts is undertaken by the county health authorities. If a contact is not within a reasonable time reported to have appeared at a clinic, the invitation is followed by an order, and if this is ignored the contact may be apprehended by the police.

In Canada, it is up to the physician who reports a case of VD to indicate whether he himself will take responsibility for tracing contacts or whether he requires the assistance of public health personnel. If he requires assistance, the information which he has obtained from the patient is passed on to a public health nurse for follow-up. When the patient attends a public clinic, however, there is an opportunity for a skilled interviewer, who may also be a public health nurse, to elicit more detailed information, and the chances of success are thereby improved.

TREATMENT OF MINORS

In Britain, West Germany and Canada a physician who treats a minor without parental consent is legally liable to a charge of assault, but it seems that physicians in Britain and Canada are usually perpared to take that risk.

In Denmark a physician who is consulted by a minor for a VD problem is not required to get in touch with the parents, and in Sweden he is expressly forbidden to do so.

HEALTH EDUCATION

In England, the Health Education Council is active in the production of posters and pamphlets for use in campaigns against VD, and some of the local health authorities produce posters advertising not only clinic services but also a telephone information service. Pamphlets about sexually transmitted diseases are distributed by the Family Planning Association, and a booklet on the subject costing 15 pence (about 40 cents) is published by the British Medical Association.

In West Germany, pamphlets containing information about venereal diseases and how to prevent them are published by some of the Land (provincial) voluntary associations concerned with health promotion and VD prevention, and by the family planning association "Pro Familia". A particularly informative pamphlet is produced by the federally-supported health education agency "Bundeszentrale für Gesundheitliche Aufklärung". This agency also publishes a superb sex education atlas for use in schools which unhappily in some parts of the country never reaches the population for which it was intended.

In Denmark most of the health education activity related to VD seems to emanate from the national health education agency "Komiteen for Sundhedsoplysning". This agency not only produces pamphlets, but also publishes a twice-yearly information bulletin about VD which is widely distributed to health professionals, educational institutions and public libraries.

In Sweden most of the health education activity related to VD is shared between the health education branch of the National Board of Health, known as the HVUD, and the Swedish Association for Sex Education, known as the RFSU. The HVUD produces pamphlets (including one in twelve languages) and a VD news bulletin similar to the one in Denmark. The RFSU, which many years ago lobbied successfully for the introduction of compulsory sex education in schools from the age of seven and now has an international reputation for the quality of its visual aids, has been conducting a vigorous campaign against VD through the prominent display of posters and the distribution of pamphlets; but the feature which makes this organization unique is the fact that it derives two-thirds of its revenue from the sale

of condoms.

In Canada pamphlets about VD are produced and distributed by most provincial health departments and by Health and Welfare Canada. Most provincial health departments also maintain film libraries from which films may be borrowed for exhibition to school audiences and other vulnerable groups.

OTHER OBSERVATIONS - BRITAIN

In England the extension of statistical reporting of all sexually transmitted diseases has led to the observation that non-specific genital infections are about 1·4 times as common as gonorrhoea in both sexes combined, and that non-specific urethritis in males is about 1·8 times as common as gonorrhoea. Research (much of it at the Whitechapel Clinic of the London Hospital) has identified chlamydia as the most frequent aetiological agent.

The increasing attention which in recent years has been focused on the sexually transmitted diseases has led to the recognition of venereology as a specialty in its own right rather than a sub-speciality of dermatology. The British Postgraduate Medical Federation organizes two courses a year leading to the Diploma in Venereology of the Society of Apothecaries of London. In the meantime the Royal College of Physicians of London has broadened the scope of the specialty still further by referring to it as genito-urinary medicine.

Many of the STD clinics in Britain are still housed in old hospital basements with separate entrances for men and women directly from the street, an arrangement which does nothing to remove the stigma from VD. A notable exception to this image is James Pringle House, adjacent to the Middlesex Hospital, where there is a dignified entrance leading to a single reception office for both men and women, where patients are seen by appointment instead of being made to wait, and where the cordiality and the decor combine to relieve patients of their anxiety and make them feel like human beings.

OTHER OBSERVATIONS - WEST GERMANY

Before the author went to West Germany he had been led to believe that brothels were licensed by the state, but this was a complete misapprehension. Prostitution is illegal. In some German cities, however, there is a tacit tripartite agreement between prostitutes, police and

public health authorities whereby the prostitutes will not be harassed by the police as long as they confine their activities to recognized houses in specified districts and present themselves regularly for medical examination. In one city visited by the author the medical examination consists of weekly smears (but not cultures) from the cervix and urethra and a quarterly serological test for syphilis. In 250 prostitutes distributed among eight houses about 60 cases of gonorrhoea are diagnosed each year by this means alone.

OTHER OBSERVATIONS - DENMARK

The State Serum Institute in Copenhagen has a large Neisseria Department which serves as a WHO International Reference Centre for gonococci. By monitoring the drug sensitivity of gonococcal strains from Greenland, the Centre is assisting the campaign against gonorrhoea in that dependency, where the population of 50,000 produces about 10,000 cases per annum.

Vending machines for the sale of condoms seem to be more plentiful in Denmark than in England, West Germany or Sweden. In most of the cities visited they are not confined to barber shops and public washrooms, but are to be found in the streets.

OTHER OBSERVATIONS - SWEDEN

At the National Bacteriological Laboratory in Stockholm research is being directed towards the improvement of transport media. The object of this research is to increase the reliability of culturing as a method of diagnosis for gonorrhoea, and to reduce the number of cultures required to establish freedom from infection.

Several hospital out-patient clinics are actively involved in the clinical and microbiological aspects of sexually transmitted diseases; these include the Southern Hospital and Danderyds Hospital in Stockholm and the University Hospital at Uppsala.

IMPLICATIONS FOR CANADA

It is the author's opinion that Canada has much to learn from the European approach to VD control, and perhaps most of all from the British system which is admired even by the Danes and the Swedes. However, since the effectiveness of the British system is attributable in part to the method by which general practitioners are reimbursed for their services, a simple transplantation to the Canadian scene is obviously impossible.

As a compromise, it might be possible to select the best features of European programs and apply them to Canada as the situation permits. These features may be summarized as follows:

(1) Statistical reporting in place of individual reporting

(2) Physical location of clinics in hospitals

(3) Establishment of clinics in smaller cities

(4) Extension of clinic activities to include management of all sexually transmitted diseases

(5) More serious attention to the investigation and epidemiological control of non-specific genital infections

(6) Special training in venereology for physicians in charge of clinics

(7) Training and increased use of public health nurses and/or social workers in contact tracing

(8) Increased use of public health nurses for health education of high risk groups

(9) Compulsory sex education in schools

(10) Increased availability of vending machines for sale of condoms

(11) Legislation to facilitate examination and treatment of minors without parental consent

Although the VD situation in Canada differs from that in the United States, there are probably enough similarities to make it worth while quoting, by way of conclusion, the following excerpt from the annual report of the Chief Medical Officer of the Department of Health and Social Security (in England) for the year 1973:

> "WHO has now published (WHO/VDT/73.386) the report of the International Travelling Seminar on Venereal Disease in the United States in which two British consultants participated. This report indicates that the rising trends in incidence of both syphilis and gonorrhoea in the U.S.A. have been caused by medical, social and behavioural factors operating in modern society which are likely to lead to a further increase in prevalence there and in other countries throughout the world. It also states that epidemiological and other methods have failed to control the spread of these diseases. There is an urgent need in the U.S.A. for physicians with special training in STD to be in charge of clinics and responsible for undergraduate and postgraduate education in the subject. This situation emphasizes the foresight of those who have developed venereal disease services in the United Kingdom over the last half-century."

Table I - Incidence of Reported Gonorrhea by Sex in England, West Germany, Denmark, Sweden and Canada, 1973

Country	Rate per 100,000		
	Male	Female	Both Sexes
England	167.4	87.0	126.1
West Germany	191.3	67.2	126.6
Denmark	384.4	278.3	331.0
Sweden	339.0	311.0	325.0
Canada	277.6*	139.9*	205.2

* Excluding Nova Scotia and Prince Edward Island, which do not report sex and age.

Table II - Five-Year Trends in Incidence of Reported Gonorrhea for Both Sexes in England, West Germany, Denmark and Sweden, 1969-73

Country	Rates per 100,000				
	1969	1970	1971	1972	1973
England	108.3	115.7	121.6	115.3	126.1
West Germany	-	116.8*	123.8	132.5	126.6
Denmark	264.1	301.5	312.9	342.0	331.0
Sweden	430.0	484.0	472.0	388.0	325.0
Canada	129.0	147.6	158.7	189.9	205.2

* Rate based on notifications during second half of 1970

Table III - Incidence of Reported Infectious Syphilis by Sex in England, West Germany, Denmark, Sweden and Canada, 1973

Country	Rate per 100,000		
	Male	Female	Both Sexes
England	5.8	0.9	3.3
West Germany	14.1	5.1	9.4
Denmark	11.0	1.9	6.4
Sweden	8.3	2.3	5.3
Canada	9.0*	2.3*	5.6

*Excluding Nova Scotia and Prince Edward Island, which do not report sex and age.

Table IV - Five Year Trends in Incidence of Reported Infectious Syphilis for Both Sexes in England, West Germany, Denmark and Sweden, 1969-73

Country	Rates per 100,000				
	1969	1970	1971	1972	1973
England	2.6	2.4	2.5	2.6	3.3
West Germany	-	10.3*	9.2	9.5	9.4
Denmark	4.6	6.2	5.8	6.5	6.4
Sweden	4.7	4.0	4.1	4.6	5.3
Canada	4.7	4.2	3.6	4.4	5.6

* Rate based on notifications during second half of 1970

Appendix A

FORM SBH 60

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Return for the quarter ended 31 DEC 1974 to be made by Physicians in charge of treatment centres

SEXUALLY TRANSMITTED DISEASES

Name and address of centre: .....

.....

		TOTAL	MALE	FEMALE
	PART A NEW CASES OF SYPHILIS			
A1	Primary			
A2	Secondary			
A3	Latent in the first two years of infection			
A4	Cardio vascular			
A5	Of the nervous system			
A6	All other late and letent stages			
A7	Congenital aged under 2 years			
A8	Congenital aged 2 years and over			
	TOTAL OF LINES A1 to A8			
	PART B NEW CASES OF GONORRHOEA			
B1	Post-pubertal infections			
B2	Pre-pubertal infections			
B3	Ophthalmia neonatorum			
	TOTAL OF LINES B1 to B3			
	PART C NEW CASES OF OTHER GENITAL INFECTIONS			
C1	Chancroid			
C2	Lymphogranuloma Venereum			
C3	Granuloma Inguinale			
C4	Non-specific genital infection			
C5	Non-specific genital infection with arthritis			
C6	Trichomoniasis			
C7	Candidiasis			
C8	Scabies			
C9	Pubic lice (pediculosis pubis)			
C10	Herpes simplex			
C11	Warts (condylomata acuminata)			
C12	Molluscum Contagiosum			
	TOTAL OF LINES C1 to C12			
	PART D NEW CASES OF OTHER CONDITIONS			
D1	Other treponemal diseases			
D2	Other conditions requiring treatment in the centre			
D3	Other conditions not requiring treatment in the centre			
	TOTAL OF LINES D1 to D3			
	GRAND TOTAL OF PARTS A, B, C & D			

PART E AGE GROUPS OF NEW CASES

		SYPHILIS (lines A1 & A2)			GONORRHOEA (line B1)		
	AGE GROUP	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
1	Under 16						
2	16 and 17						
3	18 and 19						
4	20 to 24						
5	25 and over						
	TOTAL LINES 1 to 5						

PART F LOCALITIES IN WHICH INFECTIONS TOOK PLACE

	PRIMARY & SECONDARY SYPHILIS (Lines A1 and A2)	TOTAL	MALE	FEMALE
1	In locality of centre			
2	Elsewhere in Great Britain and Northern Ireland			
3	Outside Great Britain and Northern Ireland			
4	Not known			
	TOTAL OF LINES 1 to 4			
	POST PUBERTAL GONORRHOEA (line B1)			
5	In locality of centre			
6	Elsewhere in Great Britain and Northern Ireland			
7	Outside Great Britain and Northern Ireland			
8	Not known			
	TOTAL OF LINES 5 to 8			

PART G CONTACT ACTION AND DIAGNOSES

	SYPHILIS	TOTAL	MALE	FEMALE
1	Contact action taken ie number of contacts sought			
2	Contacts attending with syphilis			
3	Contacts attending, syphilis not diagnosed			
	GONORRHOEA			
4	Contact action taken ie number of contacts sought			
5	Contacts attending with gonorrhoea			
6	Contacts attending, gonorrhoea not diagnosed			

PLEASE REFER TO ACCOMPANYING NOTES

Signed .....

Physician in charge of treatment centre

Appendix B

Ugesygeliste for ugen fra søndag d. .... til lørdag d. ....

(begge dage medregnet)

Form. 4020

Lb. nr.	Sygdomme	Under 1 år M	Under 1 år K	1-6 år M	1-6 år K	7-14 år M	7-14 år K	15-44 år M	15-44 år K	45-64 år M	45-64 år K	65 år og derover M	65 år og derover K	Ialt M	Ialt K
1.	Febris typhoidea														
2.	Febris paratyphoidea														
3.	Diphtheria														
4.	Meningitis purulenta bakteriaemia														
5.	Meningitis (andre former)														
6.	Tetanus, børn under 1 måned			×	×	×	×	×	×	×	×	×	×		
7.	» øvrige patienter														
8.	Poliomyelitis anterior acuta paralytica														
9.	Encephalitis acuta primaria														
10.	Encephalitis acuta secundaria														
11.	Ornithosis														
12.	Malaria														
13.	Gastro-enteritis acuta infectiosa (herunder salmonelloser og paradysenteria)														
14.	Scarlatina														
15.	Tonsillitis acuta														
16.	Erysipelas														
17	Tussis convulsiva, børn under 6 mdr.			×	×	×	×	×	×	×	×	×	×		
18	» » øvrige patienter														
19.	Morbilli														
20.	Rubella														
21	Varicellae														
22.	Parotitis epidemica														
23.	Hepatitis acuta														
24.	Mononucleosis infectiosa														
25.	Vertigo epidemica														
26.	Febris rheumatica														
27.	Febris catarrhalis acuta														
28.	Influenza (epidemisk)														
29.	Pneumonia														
30.	Tracheo-bronchitis acuta														
31.	Infectiones cutis neonatorum, under 1 md. (herunder pemphigus)			×	×	×	×	×	×	×	×	×	×		
32.	Scabies														
	Evt. andre sygdomme:														
	Tilsammen:														

			Under 1 år	1-12 år	13-15 år	16-19 år	20-44 år	45 år og derover	Ialt
90.	Syphilis congenita	M							
91.	(ikke tidl. diagnosticeret)	K							
92.	Syphilis acqvisita recens	M							
93.	Oprindelsesland:	K							
94.	Gonorrhoea	M							
95.		K							
96.	Ulcus venereum	M							
97.	(ikke tidl. diagnosticeret)	K							
98.	Lymphogranuloma ingvinale	M							
99.	(ikke tidl. diagnosticeret)	K							
	Tilsammen								

Her anføres kartotekkendetegn for de med syphilis anmeldte patienter.

Køn					
Fødselsdag					
Fødselsår					
Forbogstaver i efternavn					
Journ. nr. hos læge eller sygehus					

Evt. bemærkninger anføres på skemaets bagside.

ANMÄLAN OM FALL AV SMITTSAM SJUKDOM

Mottagarens anteckningar

Insjuknad den | I län | kommun (anges även för smittbärare)

Infektionsort

Arbetsplats, skola, barnhem el dyl för den anmälde

Vårdas i 1 ☐ öppen vård 2 ☐ sluten vård | Sjukhusets namn

Remitterande läkare (anges av anmälande sjukhusläkare)

Övriga uppgifter av epidemiologisk betydelse: Smittkälla, smittvägar, andra anmarkningsvärda omständigheter (t ex livsmedelshantering) vidtagna smittskyddsåtgärder m m

Beträffande venerisk sjukdom uppges dels smittkälla, dels av kontakter, i båda fallen med namn, adress, telefon och ungefärlig ålder.

Ort, datum

Läkarens underskrift, telefon

Fastställd den 3 dec 1968

Personnummer
År | mån | dag | nr | 1 ☐ M 2 ☐ Kv

Namn (ej vid veneriska sjukdomar)

Yrke/titel

Adress

Tel

Nationalitet (om ej svensk)

Allmänfarliga sjukdomar

1 ☐ Sjukdomsfall 2 ☐ Smittbärare

Grupp I (se baksidan)

☐ .....

Grupp II

☐ 7. Tyfoid
☐ 8. Paratyfoid*
☐ 9. Salmonelladiarré*
☐ 10. Bacillär dysenteri*
☐ 11. Amöbadysenteri

Grupp III

☐ 12. Meningokocksjukdom
☐ 13. Polio*
☐ 14. Primär, icke varig hjärn- och hjärnhinneinflammation*

Grupp IV (se baksidan)

☐ 15. Weils sjukdom och andra leptospiroser*
☐ 16. Epidemisk gulsot
☐ 17. Inokulationsgulsot

Grupp V

☐ 18. Difteri
☐ 19. Mjältbrand
☐ 20. Papegojsjuka och andra ornithoser*

Grupp VI (se baksidan)

☐ 21. Tuberkulos
☐ 22. Lepra

Veneriska sjukdomar

☐ 31. Syfilis a) medfödd
☐ 32. ,, b) förvärvad
☐ 33. Gonorré
☐ 34. Mjuk schanker
☐ 35. Veneriskt lymfogranulom

Övriga

Bakteriesjukdomar

☐ 41. Botulism
☐ 42. Gastroenterit, elakartad, hos barn i åldern under två år*
☐ 43. Listerios
☐ 44. Scharlakansfeber
☐ 45. Tularemi
☐ 46. Undulantfeber
☐ 47. Stelkramp

Masksjukdomar

☐ 48. Filarios*
☐ 49. Schistosomiasis*
☐ 50. Trikinos

Protozosjukdomar

☐ 51. Malaria*
☐ 52. Toxoplasmos

☐

Ev typ

Mottagarens anteckning

SoSB 40010 1973-06 50000 OB 18263 ALLF 113 73 141

Appendix D

PLEASE MAKE SURE YOU BRING THIS FORM WITH YOU WHEN YOU ATTEND

HOSPITAL OF ORIGIN:

St. Thomas' Hospital,
Lambeth Palace Road.

Dr. C.S. Nicol
Dr. J. Barrow

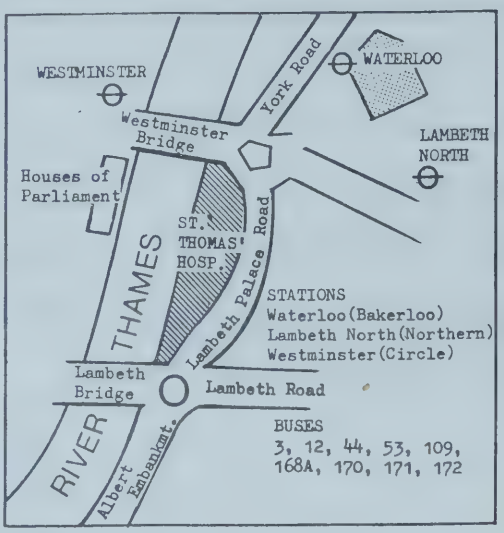
Males and Females
Mon.- Fri. 9.30 am - 6.00 pm

NO APPOINTMENT REQUIRED

Ref. No.....

Diagnosis. .....

Date.....



PLEASE RETURN TO ISSUING HOSPITAL

HOSPITAL :

Ref. No. ..... Diagnosis .....

Date .....

HIGHLIGHTS OF PUBLIC ASSISTANCE

Delaine McVey*

Table 1 presents the distribution of the public assistance caseload by reason for assistance for the quarter October - December, 1974, and compares the distribution to that of the previous quarter. Ranking of the various reasons remains unchanged, with persons with dependent children comprising the largest proportion of the caseload (38.6 per cent). Persons sixty years of age or older constituted 22.0 per cent of total caseload and those seeking assistance due to physical ill health or disability comprised 18.9 per cent. The total caseload declined minimally from an average of 28,933 for the July - September quarter to an average of 28,931 for the October - December quarter. Mental retardation and unsuited for employment as reasons for assistance increased substantially.[1] The employable caseload increased nearly four per cent in the current quarter in contrast to the previous quarter's substantial 15.8 per cent decrease. The mental ill health caseload decreased further by 3.4 per cent (see footnote 1). Persons with dependent children (primarily mothers) experienced a greater decrease (2.5 per cent) than in the July - September quarter.

Table 2 indicates the age-sex distribution of the caseload for the quarter October - December, 1974. The proportion of the caseload comprised of males increased slightly to 34.9 per cent this quarter from 34.3 per cent last quarter. There was an absolute increase from 9,927 to 10,090 males, but a drop from 19,007 to 18,841 for females. Persons 60 - 64 comprised the largest age group for both sexes. Females 20 - 24 and 25 - 29, however, accounted for 17.1 per cent of the total caseload. Except for age groups 50 - 54, 55 - 59, and 65+, all male age groups experienced absolute increases this quarter, while caseloads decreased for all female age groups from 20 to 59.

Table 3 indicates the distribution of the provincial caseload among the thirty-seven regional offices. The opening of the large Calgary Southwest regional office caused many regional offices to shift one rank lower in position this quarter. The Edmonton and Calgary regional offices combined accounted for 64.1 per cent of the total caseload. Sixteen

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*Delaine McVey is a statistical clerk in Research and Planning.

[1]These two categories, mental retardation and unsuited for employment, derive their caseloads largely from transfers from other reasons for assistance. These transfers are being made gradually as annual case reviews are made.

regional offices had decreases in caseload this quarter compared to 24 last quarter. The largest decreases in caseload, however, occurred for the Edmonton West and Calgary North and South offices which experienced partial transfers of caseload to other new or enlarged regional offices. Of the other regional offices not affected by such transfers, the largest percentage decrease was for Wainwright (4.8 per cent). Whitecourt, Slave Lake, High Level, Rocky Mountain House, and Blairmore regional offices experienced increases of 10.9 to 16.7 per cent. Wetaskiwin and Brooks had no change in average caseload size from the previous quarter.

TABLE 1 DISTRIBUTION OF CASELOAD BY REASON FOR ASSISTANCE, ALBERTA, OCTOBER - DECEMBER, 1974

Reason for Assistance	Last Quarter's Average July-September, 1974		October	November	December	Quarterly Average October-December, 1974		Percentage Change Between Quarters
	#	%	#	#	#	#	%	
Age	6,296	21.76	6,352	6,351	6,362	6,355	21.97	0.94
Physical Ill Health/ Disability	5,439	18.80	5,427	5,408	5,530	5,455	18.85	0.29
Mental Ill Health	2,122	7.33	2,062	2,044	2,047	2,051	7.09	-3.35
Mental Retardation	319	1.10	368	387	443	399	1.38	25.08
Unsuited for Employment	242	0.84	313	329	348	330	1.14	36.36
Person with Dependent Children	11,462	39.62	11,264	11,071	11,178	11,171	38.61	-2.54
Employable	3,053	10.55	3,048	3,092	3,370	3,170	10.96	3.83
TOTAL	28,933	100.00	28,834	28,682	29,278	28,931	100.0	
Increase Rate Over Previous Month			-0.51	-1.03	2.08			
Increase Rate Over Previous Quarter		-2.39						-0.01

TABLE 2 AGE-SEX DISTRIBUTION OF CASELOAD, ALBERTA, OCTOBER - DECEMBER 1974

Age Group	Males		Females		Both Sexes	
	#	%	#	%	#	%
0-19	536	1.85	1,319	4.56	1,855	6.41
20-24	847	2.93	2,442	8.44	3,289	11.37
25-29	787	2.72	2,490	8.61	3,277	11.33
30-24	647	2.24	1,913	6.61	2,560	8.85
35-39	633	2.19	1,721	5.95	2,354	8.14
40-44	760	2.62	1,571	5.43	2,331	8.05
45-49	834	2.88	1,390	4.81	2,224	7.69
50-54	830	2.87	1,370	4.73	2,200	7.60
55-59	1,050	3.63	1,434	4.96	2,484	8.59
60-64	1,637	5.66	1,904	6.58	3,541	12.24
65+	1,529	5.29	1,287	4.44	2,816	9.73
TOTAL	10,090	34.88	18,841	65.12	28,931	100.00

TABLE 3 REGIONAL DISTRIBUTION OF CASELOAD, ALBERTA, OCTOBER - DECEMBER 1974*

Regional Office	Last Quarter's Average July-September 1974		Quarterly Average October-December 1974		Percentage Change From Last Quarter	Rank Last Quarter	Rank This Quarter
Edmonton North	4,803	16.60	4,759	16.45	-0.92	1	1
Calgary South	4,611	15.94	3,902	13.49	-15.38	2	2
Edmonton West	3,102	10.72	2,820	9.75	-9.09	3	3
Calgary North	3,086	10.67	2,708	9.36	-12.25	4	4
Edmonton South	2,129	7.36	2,058	7.11	-3.33	5	5
Lethbridge	1,457	5.04	1,447	5.00	-0.69	6	6
Calgary Southwest[a]	-	-	1,202	4.15	n/a	n/a	7
Edmonton West 10	925	3.20	1,081	3.74	16.86	8	8
Grande Prairie	938	3.24	958	3.31	2.13	7	9
Red Deer	807	2.79	797	2.76	-1.24	9	10
Wetaskiwin	709	2.45	709	2.45	-	10	11
Medicine Hat	574	1.98	553	1.91	-3.66	11	12
High Prairie	485	1.68	493	1.70	1.65	12	13
Lac la Biche	388	1.34	399	1.38	2.84	14	14
Barrhead	398	1.37	387	1.34	-2.76	13	15
Vegreville	356	1.23	358	1.24	0.56	15	16
Peace River	319	1.10	329	1.14	3.13	16	17
Slave Lake	286	0.99	321	1.11	12.24	19	18
Bonnyville	300	1.04	303	1.05	1.00	17	19
St. Paul	296	1.02	289	1.00	-2.36	18	20
Edson	282	0.97	288	1.00	2.13	20	21
Drumheller	258	0.89	260	0.90	0.78	21	22
Vermilion	249	0.86	247	0.85	-0.80	22	23
Smoky Lake	225	0.78	241	0.83	7.11	24	24
Blairmore	212	0.73	235	0.81	10.85	25	26
Camrose	242	0.84	235	0.81	-2.89	23	26
Athabasca	203	0.70	211	0.73	3.94	27	27
Wainwright	210	0.72	200	0.69	-4.76	26	28
High Level	153	0.53	172	0.59	12.42	30	29
Fort McMurray	163	0.56	171	0.59	4.91	28	30
Stettler	156	0.54	163	0.56	4.49	29	31
Rocky Mtn. House	141	0.49	157	0.54	11.35	32	32
Olds	147	0.51	141	0.49	-4.08	31	33
Whitecourt	108	0.37	126	0.44	16.67	33	34
Brooks	103	0.36	103	0.36	-	34	35
Hanna	75	0.26	72	0.25	-4.00	35	36
Grande Cache	37	0.13	36	0.12	-2.70	36	37
TOTAL	28,933	100.00	28,931	100.00	-0.01		

*Adjusted to exclude Guardian Social Allowance.

[a]A new regional office, Calgary Southwest, officially opened in November 1974. Its caseload is largely composed of transfers from the other two Calgary offices.

HIGHLIGHTS OF NOTIFIABLE DISEASES*

Barbara Juchli**

These tables and comments on notifiable diseases refer to the cases reported to the divisions of local health services and social hygiene for the period October to December 1974.

Table 1 shows the geographic distribution of reported cases of notifiable diseases (excluding venereal diseases). Table 2 and Table 3 illustrate the age-sex distribution of the reported cases of notifiable diseases and of venereal diseases. Table 4 compares the number of cases and incidence rates of the notifiable diseases with the five-year means and incidence rates for the corresponding quarter, and Table 5 compares the same information for venereal diseases. Figure 1 graphs the number of reported cases of four of the notifiable diseases over a three-year period. These diseases were chosen because of the high number of cases reported relative to the other notifiable diseases.

The five diseases most frequently reported during the quarter were:

1. gonorrhoea (2198 cases)
2. streptococcal sore throat and scarlet fever (1779 cases)
3. measles (1018 cases)
4. rubella (425 cases)
5. infectious hepatitis (212 cases)

These diseases also had the highest frequency of reported cases in the July to September quarter, but their ranking changed.

Reported cases of gonorrhoea increased 12.2 per cent from the previous quarter. Female cases increased by 172 cases or 26.1 per cent over the last quarter, thereby decreasing the male/female ratio from 2.0 to 1.6. The age group 20 - 24 had the largest percentage of reported cases with 34.1 per cent. The bordering age groups, 15 - 19 and 25 - 29, contributed another 24.7 per cent and 18.7 per cent respectively, giving the 15 - 29 year age group 77.5 per cent of the total reported cases. Comparison of the average number of cases and incidence rates for the past five years with this quarter's figures shows an overall increase in total reported cases of 53.6 per cent and an increase in incidence rates of 34.5 per cent for males and 67.2 per cent for females. As

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*Tuberculosis is not included in this article; venereal diseases are separated from the other notifiable diseases for presentation.

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shown in figure 1, there was no consistent seasonal peak evident in the data: the month with the greatest number of cases was December in 1972, September in 1973 and November in 1974.

The number of reported cases of streptococcal sore throat and scarlet fever was twice the number of cases reported for July to September. The City of Edmonton and the Sturgeon Health Unit had the largest caseloads with 229 cases (12.9 per cent) and 203 cases (11.4 per cent) respectively. The 5 - 9 year age group maintained its dominance with 601 cases (33.8 per cent). The cases were evenly distributed between males and females. Both the incidence rate and number of cases were more than 100 per cent greater than the five-year averages. The monthly graph of reported cases of streptococcal sore throat and scarlet fever during 1972 to 1974 shows definite seasonal trends, March and November being the months with the highest frequencies.

Measles had the same number of reported cases as in the July to September quarter. The City of Calgary maintained the largest caseload with 485 cases. The 5 - 9 year age group contained the majority of cases (52.9 per cent) and there was an even division of the total cases between males and females. The number of cases and incidence rate in this quarter were three times greater than the previous five-year figures. Referring to Figure 1, the number of cases of measles was relatively stable throughout 1972 and the first half of 1973. In September 1973, the number of cases started to increase and an apparent peak was reached in June and July, 1974.

The number of reported cases of rubella (German measles) in the October to December quarter was triple that of the July to September quarter. The cities of Edmonton and Calgary and the Alberta East Central and Wetoka Health Units had high caseloads again this quarter, each accounting for approximately 18 per cent of the total provincial caseload. The 5 - 9 year age group had the majority of cases (223 cases). Comparing total cases and incidence rates to the five-year means and rates, it was seen that the caseload was only slightly higher (9.5 per cent) and the incidence rate was virtually the same. Over the three-year period 1972 to 1974, March appeared to be a peak month for reported cases of rubella. November and December of 1974 exhibited a noticeable rise in cases which may be indicative of an epidemic.

Infectious hepatitis increased 17.1 per cent from the July to September quarter. The caseload for this quarter was lower (by 39.6 per cent) than the five-year average, as was the incidence rate (by 43.0 per cent). Indian reserves and the Cities of Edmonton and Calgary had the highest number of cases with approximately 40 cases each. The cases were equally divided between males and females. The 5 - 9 year age group had the largest number of cases (37) followed closely by the 15 - 19 (36 cases), 20 - 24 (33 cases) and 10 - 14 (31 cases) year age groups.

TABLE 1 REPORTED CASES OF THE MORE FREQUENT NOTIFIABLE DISEASES (EXCLUDING VENEREAL DISEASES) BY CITY, HEALTH OR OTHER JURISDICTION, ALBERTA, OCTOBER - DECEMBER 1974

	Salmonellosis		Bacil.	Staph.	Diarr-		Meningo-	Strept		Aseptic Meningitis			Infect.	Serum		
	Food as vehicle	Food not mentioned	Dysen- tery	Food Poisoning	hoea of Newborn	Diph- theria	coccal Infect.	Throat Scarlet F	Per- tussis	Cox- sackie	FCHO	Not spec.	Hepat- itis	hepat- itis	Measles	Rubella
Cities																
Edmonton	-	19	5	-	-	1	-	229	1	-	-	-	40	2	13	77
Calgary	-	9	6	-	-	-	-	77	7	-	-	3	43	2	485	74
Grande Prairie	-	-	-	-	-	-	-	26	-	-	-	-	-	-	41	-
Lethbridge	-	2	1	-	-	-	-	3	2	-	-	-	24	-	3	5
Medicine Hat	-	1	1	-	-	-	-	70	-	-	-	-	1	-	1	-
Red Deer	-	2	-	-	-	-	-	26	-	-	-	-	7	-	2	7
Health Units																
Alberta East Central	-	-	-	-	-	-	-	15	-	-	-	-	2	-	3	79
Athbasca	-	-	21	-	-	-	-	142	-	-	-	-	10	-	18	49
Banff National Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Barons Eureka	-	4	-	-	-	-	-	170	-	-	-	-	3	-	11	4
Big Country	1	1	-	-	-	-	-	10	-	-	-	-	-	-	-	1
Chief Mountain	-	-	1	-	-	-	-	9	-	-	-	-	3	-	-	-
Chinook	-	-	-	-	-	-	-	64	-	-	-	-	6	-	-	1
County of Warner	-	-	-	-	-	-	-	11	-	-	-	-	-	-	-	5
Drumheller	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-
Edson	-	-	-	-	-	-	-	69	-	-	-	-	4	-	84	3
Foothills	-	-	1	-	-	-	-	3	1	-	-	-	-	-	6	4
Grande Prairie	-	3	4	-	-	1	-	96	-	-	-	-	-	1	6	-
Jasper National Park	-	-	-	-	-	-	-	16	-	-	-	-	-	-	-	2
Leduc - Strathcona	1	-	-	-	-	-	-	49	-	-	-	-	5	-	9	9
Medicine Hat	-	-	-	-	-	-	-	81	-	-	-	-	-	-	1	-
Minburn - Vermilion	-	-	-	-	-	-	-	70	2	-	-	-	2	-	2	-
Mount View	-	-	1	-	-	-	-	2	-	-	-	-	2	-	103	1
North Eastern Alberta	-	1	-	-	-	-	-	31	-	-	-	-	-	-	1	-
Peace River	-	-	12	-	-	-	-	13	-	-	-	-	2	-	25	-
Red Deer	-	2	-	-	-	-	-	24	-	-	-	-	2	1	7	4
Stony Plain - Lac Ste. Anne	-	-	-	-	-	-	-	107	-	-	-	-	2	-	3	17
Sturgeon	1	-	3	-	-	1	-	203	3	-	-	-	-	-	53	3
Vegreville	-	-	-	-	-	-	-	43	2	-	-	-	3	-	1	5
Wetoka	-	-	-	-	-	-	-	9	-	-	-	-	2	-	28	72
Other Jurisdictions																
Canadian Forces	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Indian Reserves	-	6	9	-	-	6	-	47	1	-	-	1	45	-	25	1
Northern Alberta Health Services	-	-	4	-	-	3	1	63	1	-	-	-	4	-	87	2
Other Municipalities	-	-	-	-	-	-	-	1	-	-	-	-		-	-	-
Total	3	50	69	-	-	12	1	1779	21	-	-	4	212	6	1018	425

TABLE 2 REPORTED CASES OF NOTIFIABLE DISEASES BY SEX AND AGE, ALBERTA, OCTOBER - DECEMBER 1974

Disease	Under 1		1 - 4		5 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 - 59		60+		Age not known		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Intestinal Infections																								
Typhoid fever	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Paratyphoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Salmonella infections																								
(a) with food as a vehicle	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	1	2
(b) without mention of food as vehicle	3	8	4	1	1	1	2	1	1	1	1	6	-	2	3	3	2	3	5	2	-	-	22	28
Bacillary dysentery	4	5	12	18	3	7	5	2	-	1	1	3	-	2	2	2	-	2	-	-	-	-	27	42
Staphylococcal food poisoning	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Diarrhoea of the newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Bacterial Diseases																								
Diphtheria	-	-	2	-	-	4	-	3	-	-	1	-	-	1	-	-	-	-	-	1	-	-	3	9
Meningococcal infections	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-
Streptococcal sore throat and scarlet fever	19	11	143	133	332	269	175	161	85	70	31	53	34	58	51	63	31	37	13	10	-	-	914	865
Pertussis (Whooping cough)	3	2	7	3	1	4	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	10
Virus Diseases of Central Nervous System																								
Aseptic meningitis due to enteroviruses																								
(a) Coxsackie virus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(b) ECHO virus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(c) Not specified	-	-	1	-	1	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	3	1
Western equine encephalitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Virus Diseases																								
Infectious hepatitis	-	-	9	8	18	19	22	9	12	24	15	18	10	8	13	9	3	10	4	1	-	-	106	106
Serum hepatitis	-	-	-	-	-	-	1	-	1	1	2	-	1	-	-	-	-	-	-	-	-	-	5	1
Measles	23	26	82	113	266	263	129	90	11	6	2	1	1	-	3	2	-	-	-	1	-	-	517	501
Rubella (German measles)	10	7	25	25	115	108	51	38	14	5	4	12	-	3	2	5	-	-	-	1	-	-	221	204

TABLE 3 REPORTED CASES OF VENEREAL DISEASES BY SEX AND AGE, ALBERTA, OCTOBER - DECEMBER 1974

Disease	Under 1		1 - 4		5 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 - 59		60+		Age not known		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Gonorrhoea																								
Genito-urinary	-	-	-	1	1	4	3	12	232	311	476	274	293	119	230	65	113	21	6	3	14	20	1368	830
Gonococcal infection of eye	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Syphilis																								
Congenital	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Acquired																								
(a) Early symptomatic																								
- Primary	-	-	-	-	-	-	-	-	-	-	1	-	-	-	3	-	-	-	1	-	-	-	5	-
- Secondary	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	1	-	-	-	-	1	2
- Other and unspecified	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	1	1	-	-	-	-	-	2	2
(b) Latent																								
- Early	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	2	-	-	-	-	-	2	2
- Late	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	3	1	3	1	-	-	7	3
- Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(c) Late																								
- Cardiovascular	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Central nervous system	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Other forms with symptoms	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Other and unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chancroid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lymphogranuloma venereum	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Granuloma inguinale	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

TABLE 4 COMPARISON OF THE REPORTED CASES OF NOTIFIABLE DISEASES AND INCIDENCE RATES, ALBERTA, OCTOBER - DECEMBER 1974, WITH AVERAGE CASES AND RATES FOR THE CORRESPONDING QUARTER 1969 - 1973*

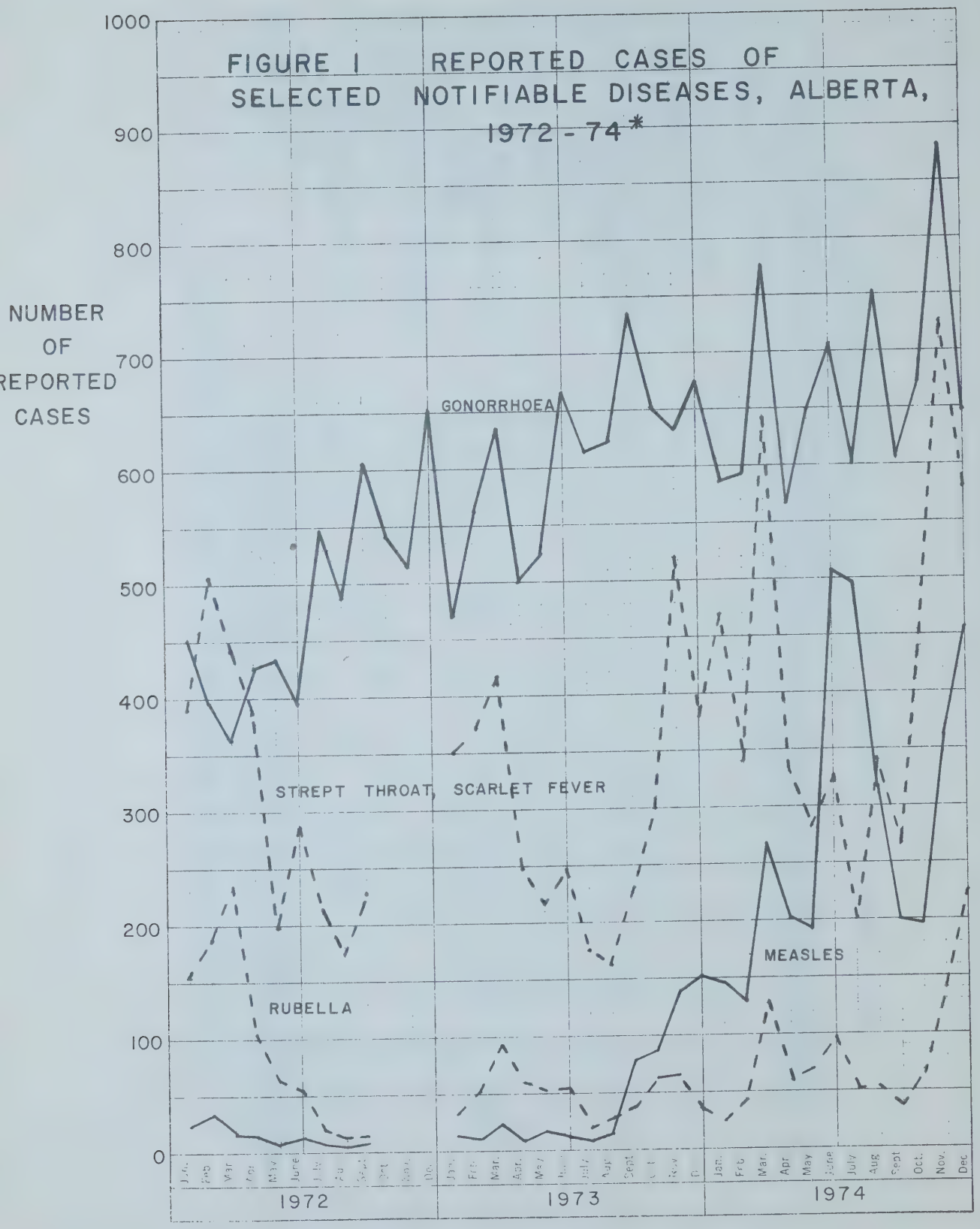
Disease	October - December 1974		Average for Fourth Quarter 1969 - 73	
	Cases	Incidence Rate per 100,000	Cases	Incidence Rate per 100,000
Intestinal Infections				
Typhoid fever	-	-	-	-
Paratyphoid fever	-	-	0.4	0.0
Other Salmonella infections				
(a) with food as a vehicle	3	0.2	20.0	1.2
(b) without mention of food as vehicle	50	2.9	118.6	7.2
Bacillary dysentery	69	4.0	78.4	4.8
Staphylococcal food poisoning	-	-	0.6	0.0
Botulism	-	-	-	-
Diarrhoea of the newborn	-	-	1.0	0.0
Other Bacterial Diseases				
Diphtheria	12	0.7	15.8	1.0
Meningococcal infections	1	0.0	2.4	0.2
Streptococcal sore throat and scarlet fever	1779	102.7	759.6	46.4
Pertussis (Whooping cough)	21	1.2	28.2	1.7
Virus Diseases of Central Nervous System				
Aseptic meningitis due to enteroviruses				
(a) Coxsackie virus	-	-	-	-
(b) ECHO virus	-	-	-	-
(c) Not specified	4	0.2	1.0	0.0
Western equine encephalitis	-	-	-	-
Other Virus Diseases				
Infectious hepatitis	212	12.2	350.8	21.4
Serum hepatitis	6	0.4	10.6	0.7
Measles	1018	58.8	292.2	17.8
Rubella (German measles)	425	24.5	388.0	23.7

*Population figures for incidence rates are from Statistics Canada's quarterly estimates - catalogue 91-001 for October 1974.

TABLE 5 COMPARISON OF THE REPORTED CASES OF VENEREAL DISEASES AND INCIDENCE RATES BY SEX, ALBERTA, OCTOBER - DECEMBER 1974, WITH AVERAGE CASES AND RATES FOR THE CORRESPONDING QUARTER 1969 - 73*

	October - December 1974				Average for Fourth Quarter 1969 - 73			
	Cases		Incidence Rate per 100,000		Cases		Incidence Rate per 100,000	
	M	F	M	F	M	F	M	F
Gonorrhoea								
Genito-urinary	1368	830	155.3	97.5	962.0	469.4	115.5	58.3
Gonococcal infection of eye	-	-	-	-	-	0.2	-	0.0
Other	-	-	-	-	-	-	-	-
Syphilis								
Congenital	-	-	-	-	0.2	0.6	0.0	0.1
Acquired								
(a) Early symptomatic								
- Primary	5	-	0.6	-	9.0	1.8	1.1	0.2
- Secondary	1	2	0.1	0.2	2.4	2.0	0.3	0.2
- Other and unspecified	2	2	0.2	0.2	2.6	3.6	0.3	0.5
(b) Latent								
- Early	2	2	0.2	0.2	9.6	5.0	1.2	0.6
- Late	7	3	0.8	0.4	6.4	4.0	0.8	0.5
- Unspecified	-	-	-	-	-	-	-	-
(c) Late								
- Cardiovascular	-	-	-	-	-	-	-	-
- Central nervous system	-	-	-	-	-	-	-	-
- Other forms with symptoms	-	-	-	-	-	0.2	-	0.0
- Other and unspecified	-	-	-	-	-	-	-	-
Chancroid	-	-	-	-	-	-	-	-
Lymphogranuloma venereum	-	-	-	-	-	-	-	-
Granuloma inguinale	-	-	-	-	-	-	-	-

*Population figures for incidence rates are from Statistics Canada's quarterly estimates - catalogue 91-001 for October 1974. The 1971 sex ratio was used to calculate the male/female population.



* DATA FOR OCTOBER TO DECEMBER 1972 WERE UNAVAILABLE FOR RUBELLA, MEASLES AND STREPTOCOCCAL SORE THROAT AND SCARLET FEVER.

Candidiasis - Infection by the fungus *Candida albicans*, most commonly associated with inflammation of the vagina (vaginitis) or mouth (thrush), and not necessarily sexually transmitted.

Caseload - The number of households, or units, assisted; these units consisting of one or more persons. Caseload is often used to refer to the collective heads of these units.

Chancroid - A sexually transmitted infection due to the bacillus *Haemophilus ducreyi*, characterized by a soft chancre or ulcer of the genitalia and often accompanied by swelling or suppuration of neighbouring lymph glands.

Chlamydia - A group of micro-organisms capable of causing inflammation of the male urethra (urethritis), inflammation of the female cervix (cervicitis), lymphogranuloma venereum (mostly in tropical countries, as described below) or trachoma (an eye disease, common in the orient).

Genital herpes - A sexually transmitted infection due to *Herpesvirus hominis* type II, characterized by vesicular lesions on the skin or mucous membranes of the genitalia.

Genital warts - Infectious warts due to a sexually transmitted virus, usually confined to moist areas of the genitalia and the female perineum.

Gonorrhoes - A sexually transmitted infection due to the gonococcus *(Neisseria gonorrhoeae)*, usually characterized in the male by a purulent urethral discharge and in the female by either no symptoms at all or a urethral or vaginal discharge, and in the absence of adequate treatment in either sex capable of spreading to other parts of the genital tract or by way of the bloodstream to the joints. Transmission can also be non-sexual, leading to ophthalmia (inflammation of the eyes) in the newborn or to vulvovaginitis (inflammation of the vulva and vagina) in young girls.

Granuloma inguinale - A sexually transmitted infection due to the bacillus *Donovania granulomatis*, common in the tropics and characterized by slowly spreading beefy-red ulcers of the genitalia and adjacent areas.

Guardian Social Allowance (an extension of the social allowance program) - An allowance for basic necessities provided by the department, in the absence of the parent(s), to a person who in the opinion of the director is properly caring for the child.

Lymphogranuloma venereum - A sexually transmitted infection due to a micro-organism of the Chlamydia group, common in the tropics and characterized by a small, inconspicuous pimple on the genitalia followed by swelling and often suppuration of neighbouring lymph glands.

Molluscum contagiosum - A virus infection of the skin, contagious but not necessarily sexually transmitted, and characterized by the appearance of one or more waxy pimples with a central depression at the site of inoculation.

Municipal Caseload - A municipality is responsible for assisting an employable person who is a resident of the municipality and
(1) was a resident of the municipality during the twelve months immediately preceding his application, and
(2) did not, during any part of these twelve months, receive material aid from the province or any other municipality.
The municipality is reimbursed 90 per cent by the province for expenditures incurred.

Neisseria - A group of bean-shaped bacteria occurring in pairs which include the gonococcus (the causal agent of gonorrhoea) and the meningococcus (the causal agent of one form of meningitis).

Non-specific urethritis - A sexually transmitted infection clinically resembling gonorrhoea in the male, but usually associated with a longer incubation period and frequently (but not invariably) caused by *Chlamydia oculogenitale*.

Pediculosis pubis - An infestation of the pubic hair by the crab louse, *Phthirus pubis*, nearly always sexually transmitted.

Reasons for Assistance - The social allowance program is available to those persons who lack the resources or income sufficient to meet their needs and those of their dependents. Eligibility for assistance is defined within the following categories; for each application, the social worker assigns a reason for assistance on the following rank order basis. That is, applicants are assigned to the first category of reason for assistance that applied to them, proceeding through the list of reasons in their specified order.

Age (Person 60 or over) - A person may be considered eligible for assistance under this reason if 60 years of age or older. Prior to November 1971, women between 55 and 60 years of age were also eligible for Social Allowance by reason of age alone.

Person with Dependent Child(ren) - This reason is applicable to the single parent family where the parent actually has custody of or is personally caring for a dependent child.

Physical Ill Health/Disability - This reason is applicable to a person with a physical disability, impairment, or illness, regardless of expected duration, which prevents rendering services for wages sufficient to meet the person's needs and those of dependents.

Mental Ill Health - This reason is applicable to persons having an obvious mental illness or a medical certificate confirming such mental illness, regardless of the expected duration.

Mental Retardation - This reason is applicable to persons who are mentally retarded. A medical certificate or assessment is required if the disability is not readily recognizable.

Employable - This reason is applicable to persons who are unemployed and seeking employment or whose employability may be under assessment, as well as persons employed full- or part-time with insufficient income. This reason also applies to persons temporarily unavailable for work because of schooling, pregnancy, or in jail for less than 90 days.

Unsuitable for Employment - This reason is applicable to cases which have been assessed as socially, psychologically, or otherwise unsuited for employment. Such cases would be transferred to other reasons for assistance after the assessment period.

Guardian Social Allowance - This is an extension of the Social Allowance program designed to assist persons acting as guardians and providing care to children placed in their homes by parents unable or unwilling to provide such care.

Recipients - In contrast to the term "caseload", this term refers to the unit heads plus their dependents. The number of recipients on assistance is approximately two or three times as great as the caseload.

Scabies - An infestation of the skin by the itch mite, *Scaroptes scabiei*, characterized by an itchy rash which may affect the fingers, wrists, armpits, flanks, buttocks and genitalia, but not necessarily sexually transmitted.

Syphilis - A sexually transmitted infection due to the spirochete *Treponema pallidum*, characterized in the primary stage by a chancre or sore on the genitalia associated with swelling of the neighbouring lymph glands, in the secondary stage by a rash on the skin, ulcers in the mouth or throat and sores or warts affecting the genitalia or anus, and in the late stages by chronic lesions affecting the heart, blood vessels, bones, joints, eyes, brain, spinal cord, liver and other internal organs. The disease is contagious only in the primary and secondary stages, and may become latent between the various stages.

Trichomoniasis - A sexually transmitted infection due to the protozoan *Trichomonas vaginalis*, characterized in the female by a vaginal discharge and sometimes irritation of the bladder, and in the male sometimes by a urethral discharge but more frequently by no symptoms at all.

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